REVISED AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

399 RIDOUT STREET NORTH
SIDE ENTRANCE, (RECESSED DOOR)
Board of Health Boardroom

Thursday, 7:00 p.m.
2013 October 17

MISSION - MIDDLESEX-LONDON BOARD OF HEALTH

The mission of the Middlesex-London Health Unit is to promote wellness, prevent disease and injury, and protect the public's health through the delivery of public health programs, services and research.

MEMBERS OF THE BOARD OF HEALTH

Mr. David Bolton
Ms. Denise Brown (Vice Chair)
Mr. Al Edmondson
Ms. Patricia Fulton
Mr. Marcel Meyer (Chair)
Mr. Stephen Orser
Mr. Ian Peer
Ms. Viola Poletes Montgomery
Ms. Nancy Poole
Mr. Mark Studenny
Ms. Sandy White

SECRETARY-TREASURER

Dr. Christopher Mackie

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

SCHEDULE OF APPOINTMENTS

7:05 – 7:25 p.m.	Ms. Trish Fulton, Chair, Finance and Facilities Committee re Item # 1 Report No. 108-13 Finance and Facilities Committee Meeting - October

REPORTS

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
Committee Reports						
1	Finance and Facilities Committee (FFC) Report - October Meeting (Report No. 108-13)	Appendix A	x	x		For the Board of Health to receive information and consider recommendations from the October FFC meeting
Other Delegation and Recommendation Reports						
2	Proposed Criteria for 2014 Budget (Report No. 117-13)	Appendix A	x	x		To seek Board input on the proposed criteria for the 2014 budget process
3	Promoting A Healthy Workplace Nutrition Environment (Report No. 109-13)	Appendix A Appendix B Call to Action: Key Messages		x		To seek Board endorsement of the Ontario Society of Nutrition Professionals in Public Health report Call to Action: Creating a Healthy Workplace Nutrition Environment
4	Board of Health Self-Assessment Survey – Proposed Revisions (Report No. 110-13)	Appendix A		x		To propose revisions to the Board of Health Self-Assessment Survey
Information Reports						
5	The MLHU Workplace Violence Initiative (Report No. 111-13)	Appendix A Appendix B			x	To outline workplace violence initiatives at the Health Unit to ensure compliance with Bill 168, an Act to amend the Occupational Health and Safety Act
6	Southwestern Ontario Youth Unite to Celebrate "World No Tobacco Day" (Report No. 112-13)	Appendix A Appendix B			x	To describe World No Tobacco Day and the work of youth from the nine southwest health units in advocating for a ban on flavoured tobacco products
7	Summary of the Research on Local Boards Of Health (Report No. 113-13	Appendix A			x	To summarize current research about how different public health governance structures impact the ability of public health agencies to improve health in their community
8	The Healthy Kids Panel – Ontario's Action Plan for Health Care (Report No. 114-13)	Appendix A			x	To outline how the recommendations of the Healthy Kids Panel Report support the Health Unit's strategic direction in the area of healthy eating and physical activity
9	Health Unit Participates in Municipal Emergency Exercises (Report No. 115-13)				x	To report that the Health Unit held its annual emergency exercise in June and participated in the testing of the emergency response plans for Middlesex Centre and Southwest Middlesex in September
10	Medical Officer of Health Activity Report - October (Report No. 116-13)				x	To provide an update on the activities of the MOH for October

CONFIDENTIAL

OTHER BUSINESS

Next scheduled Finance and Facilities Committee Meeting: Thursday, November 7, 2013 9:00 a.m.
Next scheduled Board of Health Meeting: Thursday, November 21, 2013 7:00 p.m.

CORRESPONDENCE

a) Date: 2013 September 23 (Received 2013 September 25)
Topic: London City Council endorsed support for the Ministry of Health to work with the Ontario Association of Paramedic Chiefs on changes to the dispatch protocols and language dealing with cardiac arrests
From: The Honourable Joe Fontana, Mayor, City of London
To: The Honourable Deb Matthews, Minister of Health and Long-Term Care

b) Date: 2013 September 26 (Received 2013 September 26)
Topic: alPHa Member Survey
From: Ms. Mary Johnson, President, Association of Local Public Health Agencies
To: All Board of Health Members

c) Date: 2013 September 30 (Received 2013 October 3)
Topic: The Board of Health of the Simcoe Muskoka District Health Unit expressed concern re Alcohol and gaming Commission document entitled 'Regulatory Modernization in Ontario's Beverage Alcohol Industry'
From: Mr. Barry Ward, Chair, Board of Health, Simcoe Muskoka District Health Unit
To: The Honourable Kathleen Wynne, Premier of Ontario

d) Date: 2013 October 3 (Received 2013 October 4)
Topic: The Board of Health for the North Bay Parry Sound District Health Unit passed resolutions endorsing the Ontario Society of Nutritional Professionals in Public Health (OSNPPH) – Workplace Call to Action
From: Mr. Daryl Vaillancourt, Board of Health Chairperson, North Bay Parry Sound District Health Unit
To: The Honourable Deb Matthews, Minister of Health and Long-Term Care

e) Date: 2013 October 2 (Received 2013 October 9)
Topic: Request for MOHLTC to change the current protocol for the storage and handling of vaccines
From: Ms. Amanda Rayburn, Chair, Board of Health, Wellington- Dufferin-Guelph Public Health
To: The Honourable Deb Matthews, Minister of Health and Long-Term Care

f) Date: 2013 October 2 (Received 2013 October 9)
Topic: Results of 2013 Nutritious Food Basket for Wellington- Dufferin-Guelph and request for Province to address the economic barriers that low income people experience in accessing healthy food
From: Ms. Amanda Rayburn, Chair, Board of Health, Wellington- Dufferin-Guelph Public Health
To: The Honourable Kathleen Wynne, Premier of Ontario

g) Date: 2013 October 4 (Received 2013 October 9)
Topic: Support of Menu Labelling, Bill 59: Healthy Decisions for Healthy Eating Act, 2013
To: The Honourable Deb Matthews, Minister of Health and Long-Term Care
From: Ms. Julie Roy, Chair, Board of Health for Northwestern Health Unit

ADJOURNMENT

PUBLIC SESSION - MINUTES

MIDDLESEX-LONDON BOARD OF HEALTH

2013 SEPTEMBER 19

MEMBERS PRESENT: Mr. David Bolton
Ms. Denise Brown (Vice-Chair)
Mr. Al Edmondson
Ms. Trish Fulton
Mr. Marcel Meyer (Chair)
Mr. Stephen Orser
Mr. Ian Peer
Ms. Viola Poletes Montgomery
Ms. Nancy Poole
Mr. Mark Studenny
Ms. Sandy White

REGRETS: Ms. Denise Brown

OTHERS PRESENT: Mr. Wally Adams, Director, Environmental Health and Chronic Disease Prevention Services
Ms. Marylou Albanese, Manager, Healthy Communities and Injury Prevention Team
Ms. Diane Bewick, Director, Family Health Services
Ms. Liana Bontempo, Nutritious Food Basket Volunteer
Ms. Rhonda Brittan, Public Health Nurse
Ms. Ling Chen, Medical Student
Ms. Nancy Del Maestro, Coordinator, Best Start for Babies Program
Ms. Kathy Dowsett, Manager, Family Health Services
Mr. Dan Flaherty, Manager, Communications
Ms. Krista Kolodziejzyk, Nutritious Food Basket Volunteer
Ms. Kim Leacy, Registered Dietitian
Mr. Brian Lester, Executive Director, Regional HIV/AIDS Connection (RHAC)
Ms. Laura MacDonald, Nutritious Food Basket Volunteer
Dr. Christopher Mackie, Medical Officer of Health & CEO
Mr. John Millson, Director, Finance and Operations
Ms. Sherri Sanders, Executive Assistant to the Board of Health (Recorder)
Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control Team
Ms. Louise Tyler, Director, Human Resources and Labour Relations Services
Mr. Alex Tyml, Online Communications Coordinator
Dr. Bryna Warshawsky, Associate Medical Officer of Health and Director, Oral Health, Communicable Disease & Sexual Health Services

MEDIA OUTLETS: None

Board of Health Chair, Mr. Marcel Meyer, called the meeting to order at 7:00 p.m.

DISCLOSURES OF CONFLICT(S) OF INTEREST

Chair Meyer inquired if there were any disclosures of conflict of interest to be declared. None were declared at this time.

APPROVAL OF AGENDA

It was moved by Mr. Orser, seconded by Mr. Edmondson *that the **AGENDA** for the September 19, 2013 Board of Health meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Peer, seconded by Mr. Bolton *that the **MINUTES** for the June 20, 2013 Board of Health meeting be approved.*

Carried

It was moved by Ms. Poole, seconded by Ms. Poletes Montgomery *that the Confidential Minutes for the June 20, 2013 Board of Health meeting be approved.*

Carried

REPORTS WITH EXTERNAL DELEGATIONS

1) **Harm Reduction Strategies** (**Report No. 092-13**)

Chair Meyer introduced Dr. Bryna Warshawsky, Associate Medical Officer of Health and Director, Oral Health, Communicable Disease & Sexual Health Services, to present this report. Dr. Warshawsky reported that research shows that Harm Reduction Strategies do not increase the use of injection drugs, and that the reason for programs, such as needle exchange programs, is to prevent the spread of HIV/AIDS and Hepatitis C. Dr. Warshawsky introduced Mr. Brian Lester, Executive Director, Regional HIV/AIDS Connection (RHAC).

Mr. Lester explained that if Bill C-65, an Act to amend the Controlled Drugs and Substances Act, is passed by the Federal Government, it is important to advocate that the Bill does not put additional barriers in place for setting up supervised injection sites. There is currently only one supervised injection site in Canada, i.e., **Insite** in Vancouver. In response to a question about the impact that Insite has on its community, Dr. Mackie reported that the site actually reduces the number of needles discarded in the community.

Mr. Lester explained the Counterpoint Needle and Syringe Program in the City of London in partnership with the Health Unit. The Ministry of Health and Long-Term provides the Health Unit with 100% funding to cover the cost of needles and their disposal. The Finance and Facilities Committee will review the funding contract between the Health Unit and the Regional HIV/AIDS Connection at a future meeting in order to make a recommendation to the Board of Health.

Discussion ensued about the disposal of the needles. Mr. Lester explained that the program follows the best practices which indicate that making the return of used needles mandatory before new ones can be dispensed would actually increase the prevalence of infection in the community.

Dr. Warshawsky reported that she is working on a report to present at a future Board meeting about drug use in Middlesex-London. She explained that it is difficult to quantify the number of injection drug users in the community, because not all users utilize the program and some do pick up packages for others.

In response to a question about why the Health Unit does not distribute syringes with retractable needles, Dr. Warshawsky explained that the distribution of such syringes has been tried in other communities. However, the syringes are much more expensive, and uptake is lower, so the program was not as effective.

In response to a question about why the needle exchange program is not offered in Middlesex County, Dr. Warshawsky reported that Health Unit staff members will investigate the use of the Strathroy office and/or a mobile clinic that travels to various sites within the County.

In response to a question about whether needle disposal boxes could be put into neighbourhoods by an order of the Medical Officer of Health, Dr. Mackie indicated that the range of options for dealing with need waste would be explored in an upcoming report to the Board of Health.

It was moved by Mr. Orser, seconded by Ms. Poole *that Health Unit staff conduct an environmental scan of injection drug use in Middlesex-London, including the burden of illness to the community, services offered in other communities, best practices for needle waste, and the role of the Local Health Integration Network and bring a report back to the Board of Health.*

Carried

It was moved by Ms. White, seconded by Ms. Poletes Montgomery *that Report No. 092-13 re Harm Reduction Strategies, be received for information.*

Carried

At 8:15 p.m., it was moved by Ms. White, seconded by Ms. Poletes Montgomery *that the Board of Health take a five minute recess.*

Carried

At 8:20 p.m. it was moved by Ms. Fulton, seconded by Mr. Studenny *that the meeting be called back to order.*

Carried

COMMITTEE REPORTS

2) **Finance and Facilities Committee (FFC) Report, August Meeting** (**Report No. 093-13**)
3) **Finance and Facilities Committee (FFC) Report, September Meeting** (**Report No. 094-13**)

Ms. Trish Fulton, Chair of the Finance and Facilities Committee (FFC), introduced Reports No. 093-13 and 094-13 re the August and September Finance and Facilities Committee meetings.

Dr. Mackie led the Board through the **slide presentation** that he prepared for the September 5 FFC meeting about the proposed budget planning process and the compressed timeline for 2014. He reported that at the November 1 Board of Health Retreat, the Board will discuss a high-level vision for the Health Unit and the criteria, proposed by Health Unit staff, for the budget planning process.

Business Arising from the August 1 FFC meeting

It was moved by Mr. Edmondson, seconded by Ms. White *that the Terms of Reference for the Finance and Facilities Committee be approved.*

Carried

It was moved by Mr. Peer, seconded by Mr. Studenny *that the Board of Health endorse the Board Chair to sign the 2013 service agreement for the Healthy Babies Healthy Children program as attached as **Appendix A** to Report No. 003-13.*

Carried

It was moved by Mr. Orser, seconded by Mr. Bolton *that the **minutes** of the August 1Finance and Facilities Committee be received.*

Carried

Business Arising from the September 5 FFC meeting

It was moved by Ms. White, seconded by Mr. Orser *that the Board of Health authorize the Board Chair to sign the Amending Agreement attached as Appendix C to **Report No. 004-13C**.*

Carried

It was moved by Ms. Fulton, seconded by Mr. Edmondson *that the Board of Health approve expenditures in the amount of $90,000 to cover the implementation of technology as recommended by PricewaterhouseCoopers and the additional resources of the Executive Assistant to the Board of Health to support to the FFC, as identified in Table 1 of Appendix B of **Report No. 005-13C**, it being noted that the funding would come from anticipated 2013 surplus.*

Carried

It was moved by Ms. Fulton, seconded by Mr. Orser *that the Board of Health endorse the following:*

1) *That the 2014 planning parameters include the reallocation of resources based on maximizing the value of services across the four principles of the Ontario Public Health Standards (Need, Impact, Capacity, and Partnerships/Collaboration),and further*

2) *That the 2014 planning parameters include 0% increase in municipal funding, and*

3) *That the approved parameters be communicated to the City of London and the County of Middlesex.*

Carried

It was moved by Ms. Fulton, seconded by Ms. White *that the Board of Health approve the audited Consolidated Financial Statements for the Middlesex-London Health Unit, March 31st, 2013 as appended to **Report No. 009-13C**.*

Carried

It was moved by Ms. Fulton, seconded by Mr. Edmondson *that the Board of Health receive Report No. 094-13, including the draft Minutes of the September 5 Finance and Facilities Committee.*

Carried

4) Progress on the PwC Recommendations (Report No. 095-13)

Dr. Mackie assisted Board members with their understanding of this report. He highlighted the recommendations made by PricewaterhouseCoopers (PwC) that Health Unit staff members have prioritized to implement at this time. Dr. Mackie reported that approximately $106,000 of the $135,000 contract with PwC has been spent.

It was moved by Ms. Poletes Montgomery, seconded by Mr. Studenny *that Report No. 095-13 be received for information.*

Carried

5) In Motion Community Challenge (Report No. 096-13)

Chair Meyer introduced Ms. Marylou Albanese, Manager, Healthy Communities and Injury Prevention Team, to assist Members with their understanding of this report.

It was moved by Ms. Poletes Montgomery, seconded by Mr. Bolton *that Report No. 096-13 In Motion™ Community Challenge be received for information.*

Carried

It was moved by Ms. Poletes Montgomery, seconded by Ms. Poole *that the Board of Health members challenge the Health Unit's Senior Leadership Team in the In Motion™ Community Challenge.*

Carried

More information about the Challenge will be provided to Board members via email.

ACTION REPORTS

6) Child and Youth Network (CYN) Agreement (Report No. 097-13)

Ms. White declared a potential conflict of interest with this report and abstained from voting.

It was moved by Mr. Bolton, seconded by Mr. Edmondson *that the Board of Health endorse the Family Centred Service System (FCSS) as attached as Appendix B to Report No.097-13 re Child & Youth Network: System Participation Memorandum of Understanding*.

Carried

7) Smart Start for Babies Three Year Funding Renewal Application (Report No. 098-13)

It was moved by Ms. Poletes Montgomery *that the Middlesex-London Board of Health endorse the application form for the "Smart Start for Babies: Three Year Funding Renewal".*

Carried

8) 2013 Nutritious Food Basket Survey Results for 2013 and Implications for Government Public Policy (Report No. 099-13)

It was moved by Ms. Poletes Montgomery, seconded by Mr. Edmondson *that the Board of Health:*

1. *Recommend through the Ontario Poverty Reduction Strategy consultation process that the provincial government:*
   - *a. Increase social assistance rates to a level that reflects the rising cost of nutritious food and housing.*
   - *b. Implement the immediate introduction of a $100 monthly food supplement to the basic needs allowance for all adults receiving social assistance.*
   - *c. Continue the Special Diet Allowance program, with any review or revisions developed in collaboration with Registered Dietitians.*
   - *d. Sign a housing agreement with the federal government that will commit funds for cost-sharing the five year extension of the federal Investment in Affordable Housing Program.*
2. *Endorse the Chair writing a letter summarizing these recommendations and asking support from the City of London, Middlesex County, social service agencies and local Members of Provincial Parliament.*

Carried

It was moved by Ms. Poletes Montgomery, seconded by Ms. Poole *that Mr. Al Edmondson, as Chair of the Board of Health (BOH) section of the Association of Local Public Health Agencies (alPHa)* and the *BOH Representative, South West Region, take the issue to the Alpha Board of Directors meeting on September 27, 2013.*

Carried

INFORMATION REPORTS

9) 2013 Mid-Year Performance on Accountability Agreement Indicators (Report No.103-13)

10) Locally Driven Collaborative Project: Food Skills (Report No. 100-13)

11) 2012-2013 Influenza Season in Middlesex-London– Final Report (Report No. 101-13)

12) Influenza Immunization Program 2013-2014 (Report No.104-13)

13) New Resource Lending System (Report No. 102-13)

14) Health Unit Recommendations about Electronic Cigarettes (E-Cigarettes) (Report 105-13)

Ms. Linda Stobo, Manger, Chronic Disease Prevention and Tobacco Control Team, explained that E-cigarettes are not tobacco based; however, many of them do still provide nicotine. Ms. Stobo explained that there are potential health risks of using this product and that no long-term safety studies have been completed.

15) Healthy Communities Partnership Update (Report No. 106-13)

Ms. Albanese reported that she will be making a formal presentation about the Healthy Communities Partnership at the October 8, 2013, meeting of Middlesex County. She also distributed copies of the document, **Linking Health and the Built Environment in Rural Settings: Evidence and Recommendations for Planning Healthy Communities in Middlesex County,** to each Board member. The report was developed by the Healthy Communities Partnership Middlesex-London and written by the Human Environments Analysis Laboratory at Western University in collaboration with the Health Unit. The purpose of this paper is to increase knowledge of the relationship between health and the built environment in rural contexts, while providing a local application to Middlesex County.

It was moved by Mr. Orser, seconded by Ms. Fulton *that Items No. 9 through 15 be received for information.*

Carried

16) Medical Officer of Health Activity Report - September (Report No.107-13)

Dr. Mackie proposed that the Board of Health meet in July or August in 2014 to help mitigate a lengthy September agenda.

He also reported that a location has been set for the November 1, 2013 Board of Health Retreat –The Middlesex-Centre Wellness and Recreation Centre.

It was moved by Ms. Poletes Montgomery, seconded by Mr. Orser *that Report No. 107-13 re Medical Officer of Health Activity Report – September be received for information.*

Carried

CORRESPONDENCE

There were no questions about the correspondence.

OTHER BUSINESS

Next scheduled Board of Health Meeting: **Thursday, October 17, 2013 at 7:00 p.m.**

Flu shots will be available before the October Board Meeting at 50 King Street.

ADJOURNMENT

At 9:50 p.m., it was moved by Mr. Bolton, seconded by Mr. Studenny *that the meeting be adjourned.*

Carried

_____ _____

MARCEL MEYER
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 108-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 October 17

FINANCE AND FACILITIES COMMITTEE REPORT – OCTOBER MEETING

The Finance and Facilities Committee (FFC) met at 9:00 a.m. on Thursday, October 3, 2013 (**AGENDA).** The draft minutes of this meeting are attached as Appendix A.

The following reports were discussed at the October meeting and recommendations made:

Report	Summary of Discussion	Recommendations for Board of Health's Consideration
Review of Financial Policies (**Report No. 010-13C**)	Mr. John Millson reviewed a slide presentation prepared by PricewaterhouseCoopers (PwC) to summarize their recommendations for three Health Unit finance policies. PwC has corrected the factual errors about mileage rates (page10) and the reference to Director of Education (page 19) in Appendix A of Report No. 010-13C (revised Appendix A). In addition to the planned review of all financial policies, the Committee asked Mr. Millson to bring back information about the Health Unit's corporate credit card for future discussion.	It was moved by Ms. Brown, seconded by Mr. Meyer *that the Finance and Facilities Committee recommend that the Board of Health approve that the meal allowances, identified in Policy 4-120 "Out-of-Town Travel" attached as Appendix B, be reduced to $10/$20/$30 and the per diem rate be eliminated*. Table continued on page 2

Report	Summary of Discussion	Recommendations for Board of Health's Consideration
Counterpoint Needle Exchange Program Agreement (Report No. 011-13C)	The Committee reviewed the program agreement between the Health Unit and the Regional HIV AIDS Connection	It was moved by Ms. Fulton, seconded by Mr. Bolton *that the Finance and Facilities Committee recommend that the Board of Health endorse the Board Chair to sign the Counterpoint Needle Exchange Program Agreement with the Regional HIV AIDS Connection as appended to Report No. 011-13C.*
Ministry of Health and Long-Term Care 100% Funding – Panorama Implementation (Report No. 012-13C)	The Committee reviewed the Panorama Implementation Project budget	It was moved by Mr. Bolton, seconded by Mr. Meyer *that the Finance and Facilities Committee recommend that the Board of Health approve the Panorama Implementation Project budget as attached to Report No. 012-13C.*
Strathroy Office Lease (Report No. 013-13C)	The Committee discussed the office area leased by the Health Unit in Strathroy. The lease expires on June 30, 2014.	It was moved by Mr. Bolton, seconded by Mr. Peer *that the Finance and Facilities Committee recommend that the Board of Health direct staff to perform a market assessment review and to bring back options regarding the Strathroy office lease to the Committee prior to the end of 2013.*
Generator Update - Verbal	Dr. Mackie gave a verbal update about a potential generator for the 50 King Street location.	The Committee appointed Mr. Peer, Mr. Meyer and Mr. Bolton to an ad hoc committee that will work with staff, the County and engineers to determine the best generator option for consideration.

The next scheduled meeting of the Finance and Facilities Committee is November 7, 2013.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses the Ontario Public Health Organizational Standards

MINUTES
Finance and Facilities Committee
MLHU Board Room –50 King Street, London
MIDDLESEX-LONDON BOARD OF HEALTH

2013 October 3

COMMITTEE MEMBERS PRESENT: Mr. David Bolton
Ms. Denise Brown
Ms. Trish Fulton (Chair)
Mr. Marcel Meyer
Mr. Ian Peer

OTHERS PRESENT: Dr. Christopher Mackie, Medical Officer of Health & CEO (Secretary-Treasurer for Board of Health)
Mr. John Millson, Director, Finance and Operations
Ms. Sherri Sanders, Executive Assistant to the Board of Health (Recorder)

MEDIA OUTLETS: none

At 9:00 a.m., Ms. Trish Fulton, Committee Chair, welcomed everyone to the Finance and Facilities Committee (FFC) meeting.

1. DISCLOSURES OF CONFLICT(S) OF INTEREST

Chair Fulton inquired if there were any disclosures of conflict of interest to be declared. None were declared.

2. APPROVAL OF AGENDA

It was moved by Mr. Peer, seconded by Mr. Bolton *that the agenda for the October, 3 2013 Finance and Facilities Committee meeting be accepted as circulated.*

Carried

3. APPROVAL OF MINUTES

It was moved by Mr. Peer, seconded by Mr. Meyer *that the minutes from the September 5, 2013 Finance and Facilities Committee meeting be approved.*

Carried

4. BUSINESS ARISING FROM THE MINUTES

There were no matters arising from the September 5, 2013 minutes.

5. NEW BUSINESS

5.1. Review of Financial Policies (Report No. 010-13C)

Mr. John Millson, Director, Finance & Operations, assisted Committee members with their understanding of this report using a slide presentation (Appendix A to the Report) that was prepared by PricewaterhouseCoopers (PwC) to summarize their recommendations about the Health Unit travel and accommodation expenses policy. Mr. Millson will ask PwC to correct the factual errors about mileage rates on page 10 and the reference to Director of Education on page 19. (**Revised Appendix A**)

Discussion ensued about corporate credit cards. The Committee asked Mr. Millson to bring back more information about the Health Unit's corporate credit card, including which staff members hold a Health Unit credit card, the average spending, and whether or not all cards are utilized.

Mr. Millson explained that the Health Unit's mileage reimbursement rate is based on the Canada Revenue Agency rate minus 3¢. Mileage rates are in the collective agreements; therefore, any changes to the rates must be made through negotiations. The Health Unit mileage rate is currently 51¢ per km for the first 5000 km and 45¢ per km over 5000 km. There is also a 250 km maximum mileage claim per return trip.

At 9:25 p.m., it was moved by Mr. Meyer, seconded by Mr. Peer *that the Finance and Facilities Committee go in camera to discuss a personal matter about an identifiable individual*.

Carried

At 9:30 p.m., it was moved by Mr. Peer, seconded by Mr. Meyer *that the Finance and Facilities Committee rise and report that progress was made in a personal matter about an identifiable individual.*

Carried

The revised Out of Town Travel and Accommodation Expenses policy will be posted on the Health Unit's intranet site. At the November 21 Board of Health meeting, Board members will be shown the new intranet site. The new site will host the new paper-less processes and submitting mileage reimbursements will be highlighted.

Discussion ensued about taking business class versus economy class when using VIA Rail for Health Unit business. Mr. Millson explained that all reimbursement and travel costs will be reviewed by the Senior Leadership Team (SLT), and their recommendations will be presented to the FFC for discussion and recommendation to the Board of Health. The SLT will review all of the financial policies and bring recommendations to the FFC.

It was moved by Mr. Meyer, seconded by Mr. Peer *that the Finance and Facilities Committee receive Report No. 010-13C re Review of Financial Policies for information.*

Carried

It was moved by Ms. Brown, seconded by Mr. Meyer *that the Finance and Facilities Committee recommend that the Board of Health approve that the meal allowances, identified in Policy 4-120 "Out-of-Town Travel" attached as Appendix B, be reduced to $10/$20/$30 and the per diem rate be eliminated.*

Carried

The Committee asked staff to calculate estimated savings that the new rates could realize based on expenses currently submitted for meal expenses, etc. This would allow the Board to be able to quantify savings created by PwC recommendations.

5.2. Counterpoint Needle Exchange Program Agreement (Report No. 011-13C)

It was moved by Mr. Peer, seconded by Mr. Bolton *that Report No. 011-13C be received for information.*

Carried

It was moved by Ms. Fulton, seconded by Mr. Bolton *that the Finance and Facilities Committee recommend that the Board of Health endorse the Board Chair to sign the Counterpoint Needle Exchange Program Agreement with the Regional HIV AIDS Connection as appended to Report No. 011-13C.*

Carried

5.3. Ministry of Health and Long-Term Care 100% Funding – Panorama Implementation (Report No. 012-13C)

It was moved by Mr. Bolton, seconded by Mr. Meyer *that the Finance and Facilities Committee recommend that the Board of Health approve the Panorama Implementation Project budget as attached to Report No. 012-13C.*

Carried

Ms. Brown left the meeting at 10:10 a.m.

5.4. Strathroy Office Lease (Report No. 013-13C)

It was moved by Mr. Bolton, seconded by Mr. Peer *that the Finance and Facilities Committee recommend that the Board of Health direct staff to perform a market assessment review and to bring back options regarding the Strathroy office lease to the Committee prior to the end of 2013.*

Carried

Mr. Millson added that the abovementioned assessment would include looking at the replacement of one or both of the Heating, Ventilation and Air Conditioning (HVAC) units.

Discussion ensued about details for staff to investigate when considering all leases. The following items were suggested:

- Anticipated leasehold improvements
- Commitment of landlord to items, such as HVAC, flood damage, etc.
- Commitment of landlord to cover capital additions or repairs
- How much space does the Health Unit really require?
- Access, parking
- Market value
- Costs associated with getting out of a lease

5.5. Generator Update - Verbal

Dr. Mackie gave a verbal update about a potential generator for the 50 King Street office. He reported that natural gas is an option; however, costs would be higher than with diesel. Discussion ensued about the generator, including what parts of the Health Unit need generator backup, the type of generator required and potential locations for the generator.

The Committee appointed Mr. Peer, Mr. Meyer and Mr. Bolton to an ad hoc committee that will work with staff, the County and engineers to determine the best generator option for consideration.

6. OTHER BUSINESS

The next scheduled Finance and Facilities Committee Meeting – Thursday, November 7, 2013 9:00 a.m. Room 3A, 50 King Street, London

7. ADJOURNMENT

At 10:35 a.m., it was moved by Mr. Bolton, seconded by Mr. Meyer *that the meeting be adjourned.*

Carried

_____ _____

TRISH FULTON
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 109-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 October 17

PROMOTING A HEALTHY WORKPLACE NUTRITION ENVIRONMENT

Recommendations

It is recommended:

1. ***That the Board of Health endorse the Ontario Society of Nutrition Professionals in Public Health's Call to Action: Creating a Healthy Workplace Nutrition Environment; and further,***
2. ***That the Board of Health communicate its support by completing the Endorsement Form (attached as Appendix A) and notifying the following groups of its support: Ontario Society of Nutrition Professionals in Public Health; Council of Ontario Medical Officers of Health; Association of Local Public Health Agencies; Ontario Public Health Association; the Honourable Deb Matthews, Ontario Minister of Health and Long-term Care; and, Local MPPs.***

Key Points

- Over 99% of Canadians do not meet recommendations for a healthy diet; poor eating habits contribute to an increased risk of chronic diseases like heart disease and cancer.
- Most employed adults spend at least 60% of their waking hours at work and eat at least one meal per day in the workplace.
- Essential elements of a healthy workplace nutrition environment and recommendations for action by all stakeholders are available.
- Health Unit staff were recently trained on the Health Unit's updated **Policy 8-200: Food: Promoting Healthy Choices** that provides financial, food safety and nutrition requirements for any food and/or beverages purchased for corporate business, educational or community functions with Health Unit funds.

Background

Over 99% of Canadians do not meet recommendations for a healthy diet, and these poor eating habits contribute to an increased risk of chronic disease. The workplace is an ideal setting to promote healthy eating, as most employed adults spend at least 60% of their waking hours at work and eat at least one meal per day in the workplace.

The Ontario Public Health Standards mandate that Boards of Health use a comprehensive health promotion approach to increase the capacity of workplaces to develop and implement healthy policies and programs, and to create or enhance supportive environments for healthy eating and healthy weights.

The Workplace Nutrition Advisory Group (WNAG) of the Ontario Society of Nutrition Professionals in Public Health (OSNPPH) strives to improve the nutrition environment in Ontario workplaces. The WNAG published an evidence-based, comprehensive report entitled Call to Action: Creating a Healthy Workplace Nutrition Environment©.

The Call to Action and Key Messages outline nine essential elements of a healthy workplace nutrition environment and contain recommendations for action by all stakeholders (e.g., employers, food service

operators, food distributors, union members, group benefits insurance companies, the provincial government and public health agencies).

The nine essential elements of a healthy workplace nutrition environment are:

- Organizational commitment to a positive healthy eating culture
- Supportive social eating environment
- Supportive physical eating environment
- Access to healthy, reasonably priced, culturally appropriate food
- Credible nutrition education and support for employees and their families
- Nutrition education for key decision makers and intermediaries provided by a Registered Dietitian
- Access to dietetic services
- Safe food practices and accommodation of special dietary needs
- Nutrition policies that encourage healthy eating

The WNAG is currently developing implementation guides and tools to support public health staff, workplaces and other key stakeholders to achieve the essential elements outlined in the Call to Action.

Opportunities for Action

October is Healthy Workplace Month, and the OSNPPH WNAG is seeking endorsement of the Call to Action from local public health agencies in Ontario, and from provincial and national health promotion organizations. To date, the Call to Action has been endorsed by: the Association of Local Public Health Agencies; the Ontario Workplace Health Coalition; Kingston, Frontenac and Lennox & Addington Public Health; and Algoma Public Health. As well, several other public health units are in the process of seeking their Boards' endorsement of this important initiative. It is recommended that the Middlesex-London Board of Health endorse the Call to Action and communicate its support by signing the Endorsement Form (attached as Appendix A) to facilitate the necessary action that is required across the province to bring recognition to this issue by public health agencies and all stakeholders who play a role in creating and enhancing the nutrition environment within Ontario's workplaces.

As leaders and role models for workplace wellness, Health Unit staff were recently trained on the Health Unit's updated Policy 8-200: Food: Promoting Healthy Choices (Appendix B) to promote healthy food choices, safe food handling practices and the use of local foods at Health Unit functions. This policy provides financial, food safety and nutrition requirements for any foods and/or beverages purchased with Health Unit funds for corporate business, educational or community functions. In addition, a Health Unit Registered Dietitian assists other London and Middlesex County workplaces to create healthier workplace nutrition environments. The Call to Action can be utilized by Health Unit staff to support workplaces in implementing any of the essential elements of a healthy nutrition environment.

This report was prepared by Ms. Kim Leacy, Registered Dietitian and Ms. Linda Stobo, Manager, Chronic Disease Prevention & Tobacco Control Team.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses the following requirements of the Ontario Public Health Standards (2008): Chronic Disease Prevention 4, 5, 11, 12

Appendix A

Call to Action: Creating A Healthy Workplace Nutrition Environment
Endorsement Form

Organization Name: Middlesex-London Health Unit

Contact Person: Dr. Christopher Mackie, MD, MHSC, FRCPC
Medical Officer of Health and CEO

Mr. Marcel Meyer, Chairperson
Middlesex-London Board of Health

Address: 50 King Street, London, ON N6A 5L7

Email: Christopher.Mackie@mlhu.on.ca

Phone: (519) 663-5317

Yes, I/my organization endorse(s) the *Call to Action: Creating A Healthy Workplace Nutrition Environment©*

Signature s:

_____ _____
Medical Officer of Health and CEO Chairperson, Middlesex-London Board of Health

Date: _____

OSNPPH has permission to: (select)

- ☑ Publicize the endorsement within the Call to Action document
- ☑ Publicize the endorsement on the OSNPPH website
- ☑ Refer to the endorsement in OSNPPH promotion of the Call to Action (e.g., letters to stakeholders, media releases, etc.)
- ○ Publicize quote:

Additional Comments:

Please indicate any other groups or stakeholders that may be interested in endorsing the *Call to Action: Creating A Healthy Workplace Nutrition Environment©*

Please complete this form and email a copy to info@osnpph.on.ca

MIDDLESEX-LONDON HEALTH UNIT

MIDDLESEX-LONDON HEALTH UNIT

ADMINISTRATION MANUAL

SUBJECT: **Food: Promoting Healthy Choices** **POLICY NUMBER: 8-200**
SECTION: Health and Safety Page 1 of 2

IMPLEMENTATION DATE: November 8, 2006 **APPROVED BY:** Directors Committee

---

PURPOSE

To promote healthy food choices, safe food handling practices and local foods[1] at Health Unit business, educational and community functions.

To provide requirements for healthy eating and safe food handling practices for staff who are involved in planning and organizing Health Unit functions (internal and external) where food and/or beverages will be purchased using Health Unit funds.

POLICY

The Health Unit is committed to supporting healthy food selection and safe food handling practices at Health Unit meetings, workshops, educational sessions and other events.

For the purposes of food safety considerations, a distinction is made between official Health Unit business functions and internal social functions.

Official Health Unit business, educational or community functions attended by non-Health Unit employees must serve food prepared at and/or purchased from a food premises approved under Ontario Regulation 562 (Food Premises). Home-prepared foods are permitted for Health Unit social gatherings attended only by Health Unit employees, volunteers, students, board members and their guests. For internal social functions, all home-prepared food should be prepared following safe food handling guidelines. Visit the Health Unit DineSafe Food Premises Inspection Disclosure website at to determine the status of a food premises or caterer and for additional information about safe food handling practices.

When ordering or providing meals or refreshments for Health Unit functions, staff will select healthy food choices, that is, varied and nutritious food and beverages that are consistent with the four food groups of *Eating Well With Canada's Food Guide*. It is understood that some foods that provide taste and enjoyment to healthy eating but are not part of the four food groups (e.g., salad dressing, condiments and many desserts) may be present; however, these foods are to be offered in moderation, on the side, in small portion sizes, and alongside healthier options (e.g., fruit as a dessert choice).

When selecting healthy foods, staff should choose locally produced foods over imported foods whenever possible. When requesting catering, staff must first select foods according to *Eating Well with Canada's Food Guide* that are considered healthy, nutritious, and safe. Staff may utilize the *Get Fresh Eat Local* Middlesex-London Local Food Guide available on Middlesex County's website to access farm gate sales and local farmers markets. Staff may refer to the Savour Ontario website to access information about the list of restaurants committed to serving local foods whenever possible. Not all local food providers are registered on

[1] Local foods' definitions range from foods produced within the nearby community to those produced within Ontario to those produced in Canada, which may or may not be organic. Foods produced in Middlesex County, elsewhere in Ontario and Canada are considered local from most-to-least. Labels or markers such as "Foodland Ontario" and "Product of Canada" can be used as identifiers of locally produced foods. Local foods are fresher than foods shipped long distances, enhance the local economy and reduce pollution associated with extra packaging and transportation.

this website. Staff should routinely enquire from the food providers about the availability of local ingredients as locally produced foods should be selected whenever possible.

Staff involved in the preparation and/or handling of food for Health Unit functions will adhere to safe food handling practices as outlined in **APPENDIX A, Safe Food Handling for Health Unit Functions**. Potentially hazardous food[2] that has been supplied at Health Unit events/meetings must be discarded if it has been left at room temperature (between 4º C and 60º C) for 2 hours or longer, as a precaution against causing food borne illnesses.

PROCEDURE

1.0 Manager/Director Responsibility

1.1 Ensure that staff are aware of and adhere to this policy and related appendices for corporate business, educational and community functions where food and/or beverages will be purchased using Health Unit funds.

2.0 Staff Responsibility

2.1 Food and beverages purchased using Health Unit funds must comply with **Acceptable-Non Acceptable Expenses** (**APPENDIX E to Policy 4-080, Expense Claim Forms**).

2.2 Staff must adhere to safe food handling practices for Health Unit functions (**APPENDIX A**, **Safe Food Handling for Health Unit Functions**).

2.3 Staff will refer to and follow, as appropriate, the healthy eating checklist (**APPENDIX B**, **Healthy Eating Checklist for Health Unit Functions**) when purchasing food and/or beverages using Health Unit funds.

[2] "Potentially hazardous food" means any food that is capable of supporting the growth of pathogenic organisms or the production of the toxins of such organisms. Examples of potentially hazardous food include meat, fish, milk, yogurt and cheese.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 110-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 October 17

BOARD OF HEALTH SELF-ASSESSMENT SURVEY – PROPOSED REVISIONS

Recommendations

It is recommended:

1. ***That the Board of Health Endorse the revisions to the Board of Health Self-Assessment survey, and***

2. ***That the survey be completed annually in March, and***

3. ***That an ad hoc committee, appointed by the Board Chair each year in February, review the survey results and propose recommendations for improvements in Board effectiveness and engagement.***

Key Points

- An ad hoc committee revised the Board of Health Self-Assessment survey and recommends it be completed annually in March.

In April 2013, the Board of Health asked that an ad hoc committee of the Board be created, consisting of Ms. Fulton, Mr. Peer and Mr. Meyer to work with Ms. Sarah Maaten, Epidemiologist, to revise the Board Self-Assessment tool and process to meet Board members' needs and the Ontario Public Health Organizational Standards (OPHOS). A revised self-assessment survey (Appendix A) was created consisting of fewer, more clearly written questions to address the five areas mandated in the OPHOS.

The ad hoc committee recommends that the attached survey be completed in March of each year. This meets the frequency requirement outlined in the OPHOS and the needs of the Board.

The ad hoc committee also recommends that the Chair appoint an ad hoc committee of two or three Board members each year in February to review the findings. The committee, with the Epidemiologist and Medical Officer of Health, will review anonymous findings of the survey and propose "recommendations for improvements in board effectiveness and engagement" as stated in Requirement 4.3 of OPHOS and present to the Board as a whole.

This report was prepared by Ms. Sarah Maaten, Epidemiologist.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

Board of Health Self-Assessment

Appendix A

This survey is expected to take approximately 10-15 minutes. Please complete by [enter survey completion end date]

As part of the Board's commitment to good governance and continuous quality improvement, all Board members are invited to complete this self-assessment survey. High-level results of the survey will be reported to the Board in an anonymous form without any identifying information. They will also be used to inform recommendations for improvements in board effectiveness and engagement.

Your participation is voluntary and you may choose not to participate or not to respond to all questions.The questionnaires will be kept confidential in our records for seven years to comply with our Middlesex-London Health Unit Retention Schedule.You can complete the survey online or on paper. If you complete the paper version please return it in a sealed envelope to Sherri Sanders, Executive Assistant to the Board of Health.

If you have any questions please contact Sherri Sanders, 519-663-5317, Ext. 3011, sherri.sanders@mlhu.on.ca

Please check Yes, No or Don't know for each question.

If your response is No, please provide an explanation in the comment box that appears. This information is key to identifying areas for improvement.

1. Is the Board of Health structured properly (i.e membership, size, terms of office, reporting relationships)?

- ○ Yes
- ○ No
- ○ Don't know

If no, please describe

2. Am I getting sufficient information to make informed decisions at Board of Health meetings?

- ○ Yes
- ○ No
- ○ Don't know

If no, please describe

3. Am I learning enough, both at Board of Health meetings and elsewhere, about current best practices in public health and governance in order to be an effective Board member?

- ○ Yes
- ○ No
- ○ Don't know

If no, please describe

4. Does the Board of Health take all relevant information into consideration when making decisions?

- ○ Yes
- ○ No
- ○ Don't know

If no, please describe

5. Is MLHU accomplishing our strategic outcomes as outlined in our strategic plan?

- ○ Yes
- ○ No
- ○ Don't know

If no, please describe

6. In the past year, has the Board of Health adequately responded to serious complaints of wrongdoing or irregularities?

- ○ Yes
- ○ No
- ○ Don't know

If no, please describe

7. Does the current relationship between the Board of Health and senior staff result in effective and efficient management of the public health unit?

- ○ Yes
- ○ No
- ○ Don't know

If no, please describe

What is the most important thing that you could recommend for discussion or action in order to improve the Board's performance?

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 111-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 October 17

THE MLHU WORKPLACE VIOLENCE INITIATIVE

Recommendation

It is recommended that Report No. 111-13 re The MLHU Workplace Violence Initiative be received for information.

Key Points

- Like many organizations where staff have public contact, Middlesex-London Health Unit employees are exposed to and experience incidents of Workplace Violence and Domestic Violence.
- The Board of Health is accountable for ensuring that requirements with respect to workplace violence and domestic violence in the workplace under the Occupational Health and Safety Act (OHSA) are met.
- While significant strides have been made to enhance the safety of the Health Unit's three office buildings, the Health Unit's level of compliance with the requirements of the OHSA with respect to workplace violence and domestic violence in the workplace is incomplete
- Analysis is currently underway to determine the required resources and associated costs to bring the Health Unit into full compliance with the workplace/domestic violence requirements of the OHSA, including:
    1. Identifying, assessing and controlling for all workplace violence risks; and
    2. Providing the various levels of training and skills development necessary to facilitate an appropriate organizational response to reports of workplace or domestic violence.

Background

Violence occurs in many workplaces. The Health Unit is engaged in many types of work that put our staff at increased risk of workplace violence. Also, with a predominantly female workforce, our employees are at greater risk of domestic violence, which can directly involve the workplace in some cases.

In April 2012, Ms. Sonia El Birani, a family home visitor with the Middlesex-London Health Unit (hereafter referred to as the Health Unit) Best Beginnings Team was murdered in her home, allegedly by her husband. While this violence did not involve the workplace directly, it had a profound impact on staff at many levels. Ms. Birani's murder was publicly reported in the April 13, 2012 edition of the London Free Press. She is survived by three daughters.

In March 2013, Dr. Heather Thomas, a dietitian with the Health Unit's Chronic Disease Prevention and Tobacco Control team, had a knife held to her throat while providing a food skills development course in a group home. Dr. Thomas wishes for the Health Unit to learn from the circumstances of this assault and is supportive of her name being included in this report.

Many of the Health Unit staff who interact with the public, such as tobacco enforcement officers, nurses, public health inspectors, and administrative assistants) are verbally assaulted and threatened with physical violence on a fairly regular basis.

These examples serve as reminders that Health Unit staff members are exposed to violence in the performance of their work duties or as part of the dynamic within their personal relationships. Further evidence of this reality is documented in the 2013 Summary of Employee-reported Workplace Violence (WV) Incidents (Appendix A).

Violence in the workplace is an unfortunate reality that occurs routinely in many workplace settings. In recognition of this phenomenon, the Government of Ontario passed "Bill 168, an Act to amend the Occupational Health and Safety Act with respect to violence and harassment in the workplace and other matters" in December 2009. These changes to the OHSA were due, in part, to the Coroner's Jury Recommendations from the Inquest into the murder of Lori Dupont. Ms. Dupont was a nurse who was killed at the hand of her intimate partner, Dr. Marc Daniel, in their mutual place of work, Hôtel-Dieu Grace Hospital, Windsor Ontario.

Bill 168 incorporated changes to the OHSA that require employers to take all reasonable precautions to protect workers against violence in the workplace, including domestic violence that could result in the physical harm or injury of an individual at work. The substantive content of these amendments call for all Ontario employers to: (1) develop a workplace violence policy; (2) complete a risk assessment regarding violence that may arise in the workplace as a result of the nature, type and conditions of work; (3) develop a workplace violence program; and (4) provide instruction and training for staff. The amendments took effect in June 2010.

Workplace Violence Initiatives at MLHU

The Health Unit has several measures in place that align with the requirements of Bill 168, including steps taken in response to a Ministry of Labour order in 2006:

- Comprehensive enhancements to the security of the physical environments of the three Health Unit office buildings (e.g. installation of a controlled access system);
- One-time mandatory training for all staff on "De-escalating Aggressive Behaviours"; and
- The development of a Workplace Violence Prevention policy.

However, compliance remains incomplete.

The Senior Leadership Team recently approved significant revisions to the Health Unit's Workplace Violence Policy (Appendix B) on June 5, 2013. This includes provisions related to domestic violence in the workplace and sets in place a process for the establishment of a Workplace Violence Response Team.

In addition to updating the policy, the development of a comprehensive and complementary workplace violence program is required. This will involve the revision of a number of existing policies and protocols (e.g. the security policy, personal safety measures, Code White protocol, etc.) as well as the development of new procedures (e.g. threat /risk assessment guidelines, safety planning processes, etc.). A Task Group has been established to redevelop the measures and procedures for staff members to formally report incidents of workplace violence. Resources will also be directed toward the development of a work plan to identify and prioritize additional aspects of the workplace violence program that need to be redeveloped (e.g. new employee orientation and skills development for managers). Training and skills development initiatives will also be important to the successful implementation of an effective workplace violence program.

Currently, staff are working to estimate the required resources and costs associated with bringing the Health Unit into full compliance with the workplace/domestic violence requirements of the OHSA. It is expected that the path to full compliance will require an ongoing commitment over a number of years.

Conclusion/Next Steps

One in three women around the world will be raped, beaten, coerced into sex or otherwise abused in her lifetime. Unfortunately, that violence can occur in a workplace setting. According to the Centre for Research and Education on Violence against Women and Children, seventy per cent of domestic violence victims are also abused at work by their abuser. The most common things that abusers do are repeated harassing phone calls and showing up at the workplace to harass the victim.

Furthermore, according to the Canadian Centre for Occupational Health and Safety, employees within certain sectors of the workforce, such as healthcare, may be at greater risk of experiencing workplace violence if their job functions include:

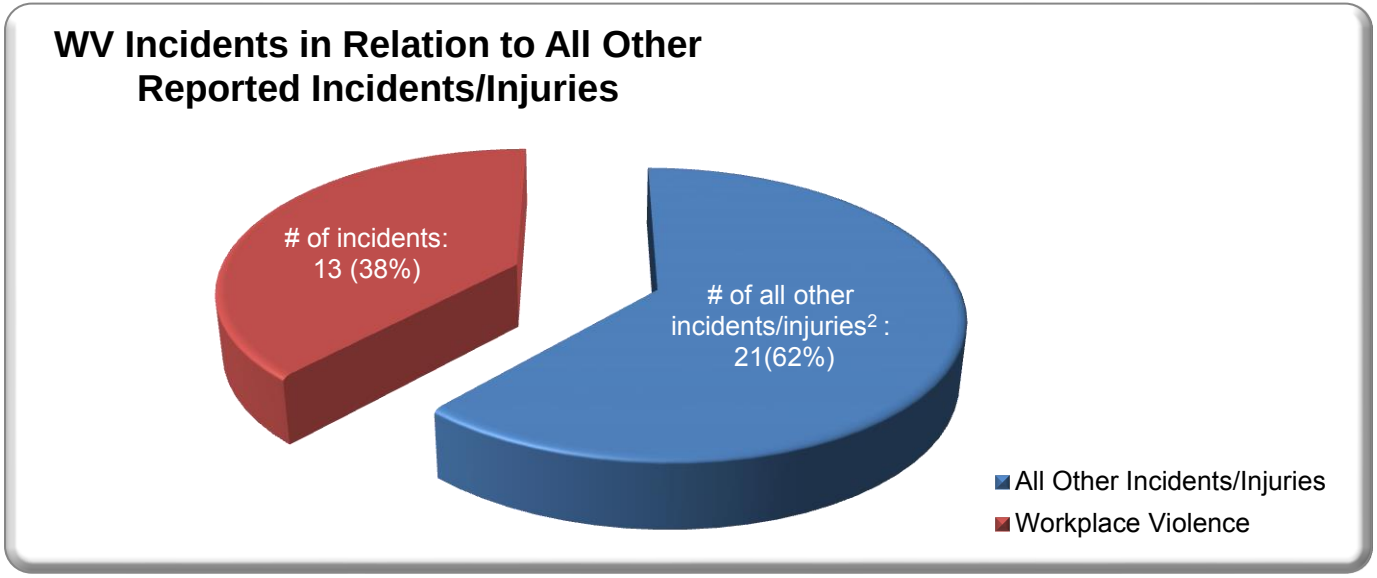
- Working or having contact with the public;
- Handling money, valuables, prescription drugs or working in premises or with individuals where alcohol and or drugs may be present;
- Carrying out inspection or enforcement duties (e.g. government employees);
- Providing service, care, advice or education;
- Working with unstable or volatile persons (e.g. social services or criminal justice system employees);
- Working alone, in small numbers (e.g. real estate agents), or in isolated or low traffic areas (e.g. washrooms, storage areas, utility rooms);
- Working in community-based settings (e.g. nurses, social workers and other home visitors).
- Having a mobile workplace (e.g. taxicab).
- Working during periods of intense organizational change (e.g. strikes, downsizing)

These risk factors apply in varying degrees to much of the work performed by Health Unit staff and are often present in the documented employee reports of workplace violence. As part of its governance and liability considerations, the Board of Health should be aware that workplace violence poses some level of occupational health risk to Health Unit staff. Furthermore, dedicated resources will be required to minimize this risk.

This report was prepared by Ms. Vanessa Bell, Manager, Privacy and Occupational Health and Safety.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

2013 | Employee-reported Workplace Violence (WV) Incidents[1]



Incident Type		# of Incidents	Description
Type 1:	External Aggressor Individual has no relationship to the workplace	4	1 – Passive Threat (inappropriate/harassing behaviours) 2 – Indecent Exposure (sexual/harassing behaviours) 1 – Verbally Aggressive Person
Type 2:	Client	6	1 – Verbal Threat of Physical Violence 1 – Written Threat of Abuse 2 – Agitated Client(s) 1 – Threatened Use of a Weapon 1 – Verbally and Physically Aggressive Premise Owner
Type 3:	Employee to Employee	0	0 – Reported incidents
Type 4:	Personal Relationship (i.e. Domestic) Violence[2]	3	1 – Reported Concern 2 – Domestic Violence Disclosures
Total Number of Incidents: **13**			

[1] The number of incidents is current as of October 02, 2013.
[2] Some of these incidents were not documented using the Health Unit's official incident reporting system.

SUBJECT: WORKPLACE VIOLENCE **POLICY NUMBER: 8-060**
SECTION: Health and Safety Page 1 of 8

IMPLEMENTATION DATE: November 7, 2007 **APPROVED BY:** Senior Leadership Team
SPONSOR: Manager, Privacy and Occupational Health and Safety

PURPOSE

To facilitate the Health Unit's compliance with Part III.0.1 (Violence and Harassment) of the *Occupational Health and Safety Act (OHSA)*.

To minimize the possibility of violent incidents occurring in Middlesex-London Health Unit workplaces and to ensure that, should such incidents occur, they are managed appropriately.

COMMITMENT

Everyone has a right to work in environments free from violence. Acts of violence are unacceptable in the workplace or at work-related activities. The Health Unit is committed to the prevention of workplace violence and will take whatever steps are reasonable to protect Health Unit staff from all sources of workplace violence. For the purposes of this policy, personal relationship violence, such as domestic violence, will also be addressed.

The Health Unit recognizes the reality of domestic violence in society and how it can affect employees and their work. We also recognize that the stigma associated with domestic violence may make an employee unwilling to disclose their situation (PSHSA, 2010, p.13). The Health Unit is committed to heightening awareness of domestic violence and minimizing the barriers to disclosure in order to increase the chance that the risk of domestic violence entering the workplace can be known, so that the appropriate safety precautions and planning can occur (Ministry of Labour, 2010, p.17).

The Health Unit will engage and empower all workplace parties to work cooperatively towards a safe, violence-free workplace.

DEFINITIONS

1. "Domestic Violence" means a pattern of behaviour used by one person to gain power and control over another with whom he/she has or has had an intimate, family or personal relationship. It may include physical violence, sexual, emotional and psychological intimidation, verbal abuse, stalking and use of electronic devices to harass and control (PSHSA, 2010, p. 1).

   "Sources of domestic violence" is a term that recognizes that this type of personal relationship violence may be committed by any individual who has a personal relationship with the employee, including a spouse, an intimate partner or a family member (Ministry of Labour, 2010, p.2).

2. "Workplace" means any land, premise, location or thing at, upon, in or near which a worker works (Occupational Health and Safety Act (OHSA), R.S.O. 1990 c.O.1, s 1(1)).

REVISION DATES (* = major revision): April 1 2009, July 26 2012, June 5 2013

3. "Workplace Violence" means any action, conduct, threat[1] or gesture of a person towards a worker in their workplace that can reasonably be expected to cause harm, injury or illness to that worker, including:
   (a) the exercise of physical force by a person against a worker in a workplace that causes or could cause physical injury to the worker;
   (b) an attempt to exercise physical force against a worker in a workplace that could cause physical injury to the worker;
   (c) a statement or behaviour that is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker (OHSA, R.S.O. 1990 c.O.1, s 1(1)).

4. "Workplace parties" means Board members, management, staff and paid students.

5. "Sources of violence" is a term that recognizes that violence may be committed by:
   a. A perpetrator who has no relationship to the workplace;
   b. A client at the workplace who becomes violent toward a worker or another client;
   c. An employee or past employee of the workplace
   d. An individual who has a personal relationship with an employee (e.g. domestic violence) (PSHSA, 2010, p.1).

6. "Visitors" is used to describe any persons who might have reason to visit or attend any Health Unit workplace, other than Health Unit employees and clients. Visitors can include members of the public, volunteers, students, community agency representatives, emergency services personnel, health care professionals, contractors, and delivery people.

APPLICATION AND SCOPE

This policy applies to all Board of Health members, staff, students, volunteers, visitors and clients of the Middlesex-London Health Unit.

Contractors will also be advised of their responsibilities and rights under this policy. In particular, contractors will be advised that they must take every reasonable precaution to ensure that violence does not enter Health Unit workplaces. This includes the duty to provide information, including personal information, related to a risk of workplace violence from a person with a history of violent behaviour, if any worker in the Health Unit can be expected to encounter that person in the course of his or her work; and this risk is likely to expose any Health Unit worker to physical injury.

POLICY

All workplace parties must participate in ensuring the workplace is free of violence.

All workplace parties must report any situation which threatens the safety of a worker or anyone else in the workplace.
A staff member shall not enter any situations in which s/he feels his/her safety is at risk from violence,

[1] Threatening may involve both words and behaviours – intimidating words, abusive language, unwelcome touching, stalking, unwelcome visits to the workplace, harassing/use of electronic devices like telephones or the internet/texting, violent or threatening gestures, "slamming" on walls/desks, damage to property (i.e. vehicle break-in, vandalism, breaking/throwing things in the office/room/area), displaying /carrying a weapon, missed attempts at use of physical force – anything that would be seen by a reasonable person as threatening violence (OHSA, R.S.O. 1990 c.O.1, s 1(1)).

attempts at violence or threats of violence. This includes verbal aggression and intimidating behaviours. Similarly, staff must leave any situation in which they feel their safety has become at risk from violence.

All employees will be advised of their right to refuse unsafe work with respect to workplace violence under section 43 of the OHSA.

The Health Unit will establish and maintain a workplace violence program that implements this policy. The program must include: (1) measures and procedures to control the risks of violence associated with the roles and responsibilities of Health Unit staff; (2) measures and procedures for summoning immediate assistance when workplace violence occurs or is likely to occur; (3) a process for workers to report incidents of or raise concerns about workplace violence; and (4) measures and procedures for how the employer will investigate and deal with incidents or complaints of workplace violence.

All reported incidents and complaints of workplace violence will be investigated and managed in a fair and timely manner, respecting the privacy of all concerned. The sharing of information, including personal information, to prevent workplace violence and address the risks of workplace violence is a required duty of employers and supervisors under the OHSA. Sharing of information will be done with respect for the confidentiality, privacy and dignity of the staff member(s) and others involved. However, the Health Unit recognizes there are limits to confidentiality when a clear threat of danger exists.

RESPONSIBILITIES

The Board of Health and the Senior Leadership Team will ensure that this policy and the supporting program are implemented and maintained. They will also ensure that all workplace parties have the appropriate information and instruction to protect themselves from violence in the workplace.

Directors and Managers will meet their supervisory responsibilities by adhering to this policy and the supporting program. They will take all reasonable steps to ensure that their direct reports have the information needed to protect themselves from workplace violence. They will ensure that staff members have the necessary supports to take appropriate precautions and follow all established safety protocols.

Staff members will work in compliance with this policy and its supporting program. All staff are responsible for bringing any incident or situation which threatens the safety of anyone in the workplace to the attention of someone in a position of authority to respond and manage these reports. Staff must also ensure that they take appropriate precautions and follow all established safety protocols and training.

CONSEQUENCES AND DISCIPLINE

Anyone who engages in workplace violence may be subject to complaint procedures, investigation, remedies, sanctions and discipline up to and including termination and referral to a police service for investigation. See also Policy 5-055 Progressive Discipline.

REPRISAL AND RETALIATION FORBIDDEN

Anyone who has in good faith made a report, raised a concern, provided information, taken action or made decisions regarding a concern or incident of workplace violence is protected from reprisal. Anyone engaging in reprisal may be the subject of a complaint and/or disciplinary measures under Policy 5-055, Progressive

REVISION DATES (* = major revision): April 1 2009, July 26 2012, June 5 2013

Discipline, up to and including termination of employment.

POLICY REVIEW

The Manager, Privacy/Occupational Health and Safety in consultation with the Joint Occupational Health & Safety Committee (JOHSC) will review the Workplace Violence Prevention policy annually, and forward any recommended changes to the Senior Leadership Team for consideration and approval.

PROCEDURES

1.0 Measures to Assess the Risk of Workplace Violence

1.1 The Senior Leadership Team will ensure that a workplace violence risk assessment is conducted and remains current for all Health Unit workplaces (e.g. office buildings, clinics, restaurants, schools and homes). The risk assessment will take into account:

(a) the types of activities that staff members participate in (e.g. handling cash);
(b) the conditions of work (e.g. working alone, in isolation or at night);
(c) circumstances specific to the workplace (e.g. geographic location of the workplace);
(d) circumstances that are common to similar workplaces (i.e. other public health units).

1.2 The results of this risk assessment will be communicated to the Joint Occupational Health and Safety Committee (OHSA, R.S.O. 1990 c.O.1, s. 32.0.3. (3))

1.3 Directors/Managers will ensure that staff is aware of all risks associated with the workplace and any activities specific to their role.

1.4 A staff member must discuss potential risk situations s/he identifies with his/her Director/Manager in advance of entering the situation.

2.0 Measures to Control the Risk of Workplace Violence

2.1 The Senior Leadership team will ensure that controls are in place to address all of the risks identified in the workplace violence risk assessment. For example, additional lighting may be installed to address poorly lit parking areas or security protocols may be enhanced to address the disclosure of an employee's potentially violent personal relationship.

2.2 To control or minimize the risk of an incident of workplace violence, staff members are empowered to trust their instincts and not enter any situation in which they feel their safety is at risk from violence, attempts at violence or threats (i.e. verbal or behavioural).

2.3 All staff members must know and follow the Personal Safety Guidelines for Health Unit Staff .

2.4 When staff members raise potential risk situations with the Director/ Manager, the Manager/Director will work with the staff member to determine a course/plan of action to protect safety for the particular situation and circumstances, and may consult other staff members (e.g. Manager, Privacy/Occupational Health and Safety, the Purchasing and Operations Administrator, Director, Human Resources and Labour Relations and external resources (e.g. Police Services or

the London Abused Women's Centre).

3.0 Procedures to Summon Immediate Assistance

3.1 Any staff member who feels that they or anyone else is in immediate danger should call 9-1-1 to request assistance from the police service, ambulance or fire personnel. Within Health Unit buildings, staff must dial 9 + 9-1-1.

3.2 Staff should also be familiar with the Health Unit Panic Alarm Protocol. Panic alarms have been strategically placed within health unit office locations (e.g. reception areas). All staff members should familiarize themselves with the alarm locations and the Panic Alarm Protocol. It is important to note that a panic alarm should never be considered as an alternative to calling for emergency first responders (i.e. police/fire/ambulance). These alarms primarily serve to enable a staff member to call for rapid assistance to deal with someone who is argumentative, hostile or appears to be in physical, mental or medical distress.

3.3 The Health Unit has established a "Code White" (i.e. Violent/Behavioural Situation) protocol as part of its emergency preparedness program. All staff members are required to familiarize themselves with this protocol. The "Code White" protocol may be enhanced through the use of the public address system for the office locations where this technology is supported (i.e. 50 King Street).

4.0 Reporting concerns about workplace violence (including domestic violence)

4.1 All workplace parties and visitors are to bring any situation which threatens the safety of the workplace to the attention of a Manager or Director (verbally or in writing).

4.2 Concerns presenting imminent danger will be reported to a police service (i.e. London, Strathroy-Caradoc or OPP).

4.3 If the staff member's Manager/Director is not available and the concern does not require police intervention but does require action to ensure immediate safety, one of the following individuals must be contacted and/or consulted: (1) another Manager or Director; (2) the Director of Human Resources; or (3) the Manager, Privacy and Occupational Health and Safety; or (4) a member of the JOHSC.

4.4 Reported concerns must also be documented on an *Employee Incident Report (EIR)* to ensure that all the appropriate information has been gathered and the appropriate inter-agency and external agency notifications are initiated.

4.5 All reported concerns will include any relevant supporting records, such as e-mail, voicemail, photographs and the like.

5.0 Reporting incidents of physical violence

5.1 In the event of an incident of workplace violence, follow the procedures under 3.0 of this policy to summon immediate assistance.

5.2 Within 24 hours (or as soon as it is safe to do so), the staff member will notify their Manager or

Director of the incident.

5.3 The Manager or Director will ensure that the MOH/CEO, Human Resources and Occupational Health and Safety are notified of the incident.

5.4 An EIR must be completed within 48 hours of the incident and submitted to Human Resources.

6.0 How reported concerns or incidents of workplace violence will be managed

6.1 Manager/Director-led response

6.1.1 The Manager or Director who receives a report regarding a concern or incident of workplace violence will:

(a) initiate the response process by taking the appropriate steps to put immediate or interim measures in place, necessary for the protection of the staff member and others in the workplace.

(b) act as the lead in communication with the staff member affected by the violence.

(c) gather information and document the concern.

(d) consult promptly with the Service Area Director, the MOH, Director HRLR, the Manager Privacy and Occupational Health and Safety and others as required to establish a working plan of response, if needed beyond the measures in place and actions already taken /to be taken in the initial response, or as the assessment indicates.

6.2 The Workplace Violence Response Team

6.2.1 In incidents and threat situations requiring additional/ongoing security, safety measures, supports, administrative management or accommodation measures, a Workplace Violence Response (WVR) Team is formed.

6.2.2 WVR Membership will vary in size and composition, depending on the particular circumstances of the concern, threat or incident. At a minimum, the response team will consist of: (1) the affected staff member(s)' Manager/Director; (2) the Manager, Privacy/Occupational Health and Safety; and (3) the Director Human Resources/Labour Relations. Other internal (e.g. Operations) or external (e.g. police, legal counsel) may also be requested to participate as a member of a WVR team.

6.2.3 The WVR team acts as the coordinating body for the Health Unit's response.

6.2.4 The team may operate informally or formally (depending on the nature of the report) and will meet as often as is necessary to assign tasks and ensure that security measures are established, safety plans are developed, supports for the affected staff member(s) are provided and that decisions and actions are implemented and accurately documented.

6.2.5 The WVR team will:
(a) Assess the risks;
(b) Consider safety measures (to protect the directly-affected individual) and security measures (to protect the safety of the workplace and staff or others in it).
(c) Put a short or long-term response plan in place.
(d) Coordinate implementation of the response plan.
(e) Prepare a summary of the response actions and measures taken, with timeline, for inclusion with the record of the incident.
(f) Continually reassess the situation and the response plans.
(g) Arrange a post-response consultation with all involved in the response to identify gaps, areas for improvement and actions or response measures to be implemented in similar situations in future.

7.0 Support for staff experiencing or affected by violence

7.1 Staff who experience violence, observe or are otherwise affected by a threat or incident of workplace violence will be encouraged to get support and information through the Health Unit and referrals to other sources of help, which include:
(a) the Director/Manager;
(b) access to professional support (e.g. MLHU Employee Assistance Program (EAP) or other trained facilitators, such as a Critical Incident Stress Management Debriefer; or
(c) peer consultation.

RELATED POLICIES

This Workplace Violence Policy provides the overarching framework for the Health Unit's workplace violence program. Detailed information, instructions, protocols, forms and procedures (are) available in the Workplace Violence Program manual.

A number of existing administrative policies and procedures relate to this policy, employee safety and critical incidents.

See also:
Policy 3-040 Building Security
Policy 5-075 Human Rights Recognition
Policy 5-120 Employment Harassment
Policy 5-095 Complaints
Policy 8-130 Personal Safety
Policy 8-040 Critical Injury or Fatality
Policy 8-030 Non-Employee Injury-Incident
Policy 8-020 Employee Injury/Incident

REFERENCES

REVISION DATES (* = major revision): April 1 2009, July 26 2012, June 5 2013

Ministry of Labour. (2010). Workplace Violence and Harassment: Understanding the Law. Queen's Printer for Ontario.

Occupational Health and Safety Act, RSO 1990, c O.1. Retrieved from: http://www.canlii.org/en/on/laws/stat/rso-1990-c-o1/latest/rso-1990-c-o1.html

Public Services Health & Safety Association (PSHSA). (2010) Addressing Domestic Violence in the Workplace: A Handbook. Toronto, ON: Public Services Health & Safety Association (PSHSA).

Public Services Health & Safety Association (PSHSA). (2010). Fast Facts: Workplace Violence: Complying with the Occupational Health and Safety Act. Toronto, ON: Public Services Health & Safety Association (PSHSA).

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 112-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 October 17

SOUTHWESTERN ONTARIO YOUTH UNITE TO CELEBRATE "WORLD NO TOBACCO DAY"

Recommendation

It is recommended that Report No. 112-13 re Southwestern Ontario Youth Unite to Celebrate World No Tobacco Day be received for information.

Key Points

- World No Tobacco Day is celebrated every year on May 31 in an effort to reduce worldwide consumption of tobacco industry products and to raise awareness about tobacco industry tactics globally.
- This year, approximately 60 young people from 9 public health units gathered in London to profile how the tobacco industry directs marketing tactics to young people, and to advocate for a ban on the marketing and sale of any new or existing tobacco industry product that contains candy or fruit flavours.

Background

World No Tobacco Day is celebrated each year on May 31 by the World Health Organization (WHO) and other tobacco control partners working to raise awareness about the harms associated with tobacco use. Tobacco use is the single most preventable cause of death globally and is responsible for killing one in ten adults worldwide.

The theme for this year's World No Tobacco Day was "banning tobacco advertising, promotion and sponsorship."

Studies have shown that bans on tobacco advertising can lead to a decrease in the number of people initiating and continuing tobacco use. If tobacco advertising and sponsorship were banned, this would effectively reduce tobacco product demand because the tobacco industry would not be able to use their deceptive or misleading tactics to target and attract new users, particularly children and youth.

The Southwest Tobacco Control Area Network (SW TCAN), comprised of the nine public health units in southwestern Ontario, Smokers' Helpline and the Program Training and Consultation Centre, decided to join forces to support youth from across the region so that they could celebrate World No Tobacco Day together.

One Life One You

The One Life One You Youth Leaders are employed by the Health Unit. The six (6) Youth Leaders are between the ages of 15 and 18 years and come from different neighbourhoods in London. They meet weekly with a Health Promoter to discuss health issues and trends that are of concern to youth in the community. The Youth Leaders plan and implement interactive educational activities/events and health promotion campaigns to address these issues by reaching out to other youth in the community. While most activities of

the One Life One You group are related to tobacco, they are also able to address other health topics important to the group.

The Event

On May 31, 2013, approximately sixty (60) youth from across Southwestern Ontario gathered at Market Square at the Covent Garden Market (London) from 4:00 to 5:30 p.m. to highlight the health risks associated with tobacco use and educate the community about the tactics used by the tobacco industry to recruit new users, such as the addition of candy and fruit-flavouring to tobacco products and the use of attractive packaging.

The Health Unit's One Life One You youth group and Health Promoter worked with eight other health unit youth groups in the planning and implementation of this regional event. One Life One You recruited youth volunteers and promoted the event through several media channels, including the Health Unit's website, and also distributed posters throughout the City of London (Appendix A).

The World No Tobacco Day youth advocates were dressed from head to toe in colourful morph suits and as life-sized tobacco products. They also participated in a flash mob dance and performed a song in a united effort to say that "cancer shouldn't come in a candy wrapper" (Photographs attached as Appendix B).

Community partners that attended the event included the Canadian Cancer Society, the Ontario Lung Association, the Youth Advocacy Training Institute, the Sir Wilfrid Laurier Secondary School Robotics Team, and staff from the nine health units.

The Ontario Minister of Health and Long-Term Care, the Honourable Deb Matthews, and Middlesex-London Health Unit's Medical Officer of Health, Dr. Christopher Mackie congratulated the youth for their continued determination to tackle the tobacco industry and their ongoing efforts to support the Ontario Government's commitment to lowering smoking rates in Ontario.

Media coverage for this event included two newspaper articles, two radio interviews and one television news story. In addition, a total of 135 signatures were collected on a petition advocating for a Federal ban on the marketing and sale of any new Tobacco Industry product that contains youth-friendly candy or fruit flavours.

Conclusion/Next Steps

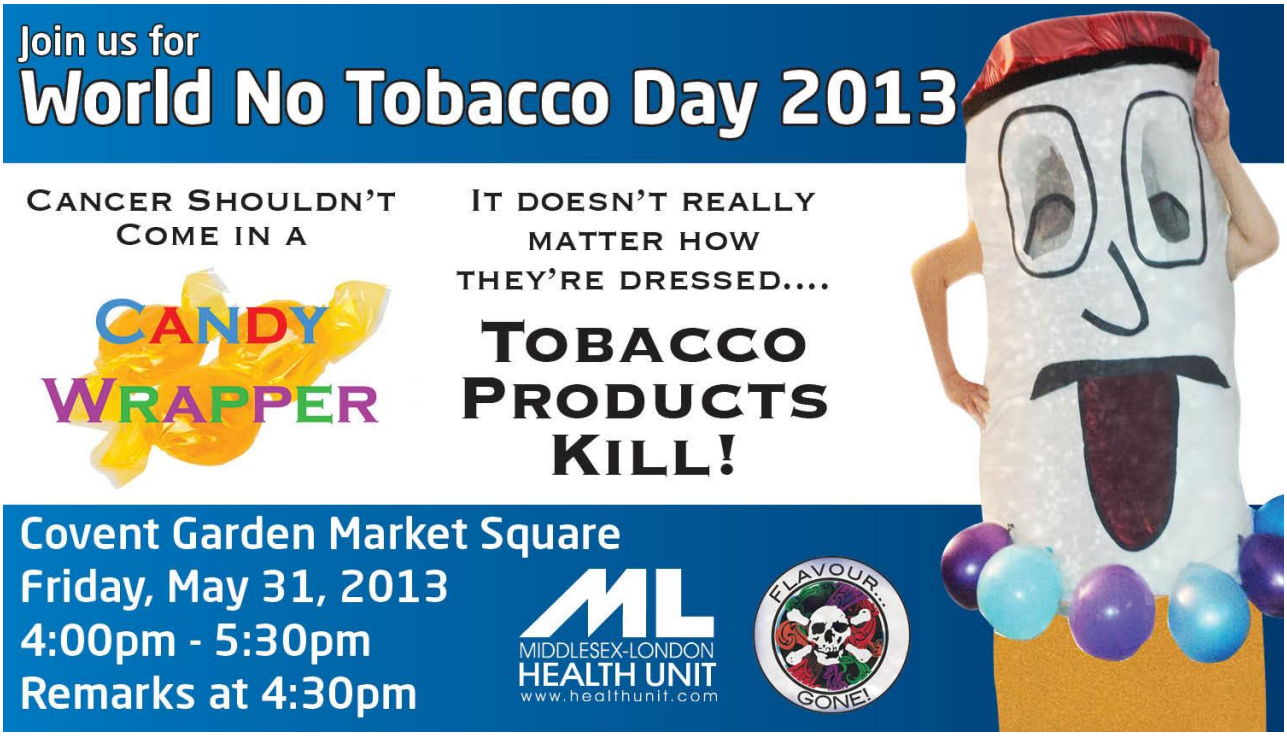
Petitions signed at the World No Tobacco Day event have been delivered to the Northwest Tobacco Control Network, which is the TCAN leading the project "Flavour Gone" advocating for a federal ban on all flavours to all tobacco products. Next steps will include continued efforts to support the federal ban on flavoured tobacco products and to support the "Freeze the Industry" campaign, which was spear-headed by youth in the East TCAN, and calls for a complete moratorium on any new tobacco product being introduced into the market place.

This report was prepared by Ms. Tanya Weishar, Health Promoter; Ms. Sarah Neil, Public Health Nurse; and Ms. Linda Stobo Manager, Chronic Disease Prevention &Tobacco Control Team.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards:
Foundations: Principles 1, 2; Comprehensive Tobacco Control: 6, 7, and 11

Poster Used to Promote the World No Tobacco Day Event **Appendix A**



Photographs Taken at the World No Tobacco Day Event **Appendix B**

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 113-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 October 17

SUMMARY OF THE RESEARCH ON LOCAL BOARDS OF HEALTH

Recommendation

It is recommended that Report No. 113-13 re Summary of the Research on Local Boards of Health be received for information.

Key Points

- Research findings demonstrate that local Boards of Health are an important asset for health units because they link the agency to the community, can help stabilize funding levels and have influence in municipal policy-making.
- High-performing Boards of Health have a unified culture, have knowledgeable membership from both health professionals and political officeholders, influence municipal policy-making, and have a positive relationship with the agency CEO.

Background

The Foundational Standard of the Ontario Public Health Standards requires public health practitioners to maintain awareness of relevant research literature and to implement research findings that lead to the most effective public health practices, where possible. In June 2013, new research examined how different public health governance structures (e.g., a local board, a regional board, a provincial board) impact the ability of public health agencies to improve health in their community. Staff then conducted a broader scoping review of other relevant literature on this topic. While there is limited evidence in this area, three relevant research findings are presented below. The bibliography for the review is attached as Appendix A.

Finding #1 Local Boards of Health are Important

Various studies have reported that a local board of health (LBOH) "is an important strength for local public health organizations." This is because a LBOH is "the link between the health [unit] and community. This link, together with policies, will drive the citizen engagement needed to improve public health outcomes. It is vital for the public health field to continue engaging and utilizing [LBOHs], in addition to health [units]." Specifically, research that has compared different public health governance structures found that presence of a LBOH is associated with:

- Stability of funding and higher funding (~17% higher in communities with a LBOH). Higher per capita local public health spending is related to better health unit performance and greater vaccine coverage, but only when the LBOH is engaged in municipal policy-making
- Improved emergency preparedness
- Lower rates of sexually transmitted infections in rural areas (due to better collaboration with community partners)
- Greater economic impacts on communities

Finding #2 Some Factors Appear to Influence LBOH Effectiveness

A number of factors have been reported to influence LBOH effectiveness: culture, composition, duties, and relationship with the CEO. Regarding board culture, a study that examined LBOH reported the "importance of leadership and board culture in promoting a preventive agenda." They reported that boards with a united culture and vision for advancing public health were better able to establish agency priorities. They give the example of a board with a united culture for reducing health inequalities: "there is no doubt the whole health inequalities agenda is now running through the organization."

With regards to board composition, it appears that "the relatively healthiest governance type is an empowered [LBOH] comprised of a combination of health professionals and political officeholders, but where neither group has a majority." Numerous studies supported the importance of having local elected officials on a LBOH, as elected officials are (a) central to the municipal policy-making process, and (b) act as a link between the public health organization and the community. Other important factors include having a LBOH that (a) is smaller in size, (b) has the necessary skills and knowledge (including public health knowledge), (c) uses subcommittees (as this enhances board member understanding of the organization) , (d) engages in performance assessment (as this also enhances board member knowledge), and (e) has diverse membership that represents the community.

Various authors have reported the importance of the board's duty to influence municipal policy, as this has been shown to be associated with increased local public health performance.

Regarding CEO relations, various authors have reported that the board-CEO relationship must be "expertly maintained" through experience, open communication and staying true to the mission of the organization. A particularly important role appears to be "inspiring a shared vision" between the board and CEO that will overcome competing individual interests. Furthermore, the CEO reporting to a high-preforming LBOH should (a) educate board members, (b) ensure all members are clear about their roles/responsibilities, (c) clearly communicate to entire board, not just chair/board officers, (d) listen to thoughts and viewpoints of all board members, (e) "do more" than just give reports, and (f) respect the time of board members.

Finding #3 Challenges and Unknowns

However, a number of challenges and unknowns were also reported. Challenges include recruiting LBOH members with the right skills and experience and that citizen LBOH members who are supposed to represent community interests often report feeling disconnected from the community, unclear on their role, restricted by the system, and responsible for things over which they have limited control.

Given the limited research on this topic, there is still much that is unknown or only supported with limited evidence from one jurisdiction. For example, there is no research on the relationship between LBOH performance and whether or not the public health agency is positioned within a municipal government structure. For these reasons, authours recommend exercising caution interpreting these findings.

This report was prepared by Mr. Ross Graham, Manager of Strategic Projects.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

Appendix A - Bibliography

1. Bhandari, M. W., Scutchfield, F. D., Charnigo, R., Riddell, M. C., & Mays, G. P. (2010). New data, same story? Revisiting studies on the relationship of local public health systems characteristics to public health performance. *Journal of public health management and practice, 16*(2), 110–117.
2. Burke, R. E., & Friedman, L. H. (2011). *Essentials of management and leadership in public health*. Sudbury, MA: Jones and Bartlett Publishers.
3. Chessie, K. (2009). Health System Regionalization in Canada's Provincial and Territorial Health Systems: Do Citizen Governance Boards Represent, Engage, and Empower? *International Journal of Health Services, 39*(4), 705–724.
4. Gauld, R. (2010). Are elected health boards an effective mechanism for public participation in health service governance? *Health expectations, 13*(4), 369–378.
5. Greene, J. (2011). Why board diversity matters. *Hospitals & health networks, 85*(1), 37–38, 40.
6. Hays, S., Toth, J., Poes, M., Mulhall, P., Remmert, D., & O'Rourke, T. (2012). Public Health Governance and Population Health Outcomes. *Frontiers in Public Health Services and Systems Research, 1*(1). Retrieved from http://uknowledge.uky.edu/frontiersinphssr/vol1/iss1/4
7. Hyde, J., Arsenault, L., Waggett, J., Mills, B., Cox, H., MacVarish, K., & Fried, L. (2012). Structural and organizational characteristics associated with performance of essential public health services in small jurisdictions: findings from a statewide study in Massachusetts. *Journal of public health management and practice, 18*(6), 585–594.
8. Late, M. (2005). Local boards of health using assessment tool to improve health. *The Nation's Health*, 5.
9. Marks, L., Cave, S., Hunter, D., Mason, J., Peckham, S., & Wallace, A. (2011). Governance for health and wellbeing in the English NHS. *Journal of health services research & policy, 16*(Suppl 1), 14–21.
10. Mays, G. P., & Smith, S. A. (2009). Geographic variation in public health spending: correlates and consequences. *Health services research, 44*(5 Pt 2), 1796–1817.
11. Mays, G. P., & Smith, S. A. (2011). Evidence links increases in public health spending to declines in preventable deaths. *Health Affairs, 30*(8): 1-9.
12. Minnesota Public Health Research to Action Network. (2011). Factors Associated with Local Public Health Department Performance: Literature Review. Published online at: www.health.state.mn.us/divs/opi/pm/ran/docs/1110ran_litreview.pdf
13. Ransom, J., Schaff, K., & Kan, L. (2012). Is there an association between local health department organizational and administrative factors and childhood immunization coverage rates? *Journal of health and human services administration, 34*(4), 418–455.
14. Rodriguez, H. P., Chen, J., Owusu-Edusei, K., Suh, A., & Bekemeier, B. (2012). Local Public Health Systems and the Incidence of Sexually Transmitted Diseases. *American journal of public health, 102*(9), 1773-1781.
15. Rutsohn, P., & Kent, C. (2010). An assessment of the economic impact of Local Boards of Health on West Virginia's economy. *Hospital topics, 88*(3), 67–74.
16. Savoia, E., Rodday, A. M., & Stoto, M. A. (2009). Public Health Emergency Preparedness at the Local Level: Results of a National Survey. *Health Services Research, 44*(5 Pt 2), 1909–1924.
17. Schneider, E., Fallon, M. M., & Valasek, T. (2012). Local board of health authority to address obesity. *American journal of public health, 102*(Suppl 1), S6.
18. Wilson, K. (2004). The complexities of multi-level governance in public health. *Canadian Journal of Public Health, 95*(6), 409-412.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 114-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 October 17

THE HEALTHY KIDS PANEL – ONTARIO'S ACTION PLAN FOR HEALTH CARE

Recommendation

It is recommended that Report No. 114-13 re The Healthy Kids Panel – Ontario's Action Plan for Health Care be received for information.

Key Points

- About 30 % of children and youth - almost one in every three children – are now at an unhealthy weight.
- By 2040, up to 70 % of today's children will be overweight or obese adults and almost half of children will be at an unhealthy weight.
- In an effort to promote a healthier start in life, the Provincial Government's Ontario Healthy Kid's Panel has set a goal for Ontario to achieve a 20% reduction in childhood obesity by 2018.
- Current Health Unit programming includes a multi-strategy approach to reduce childhood obesity.

Background

A priority of Ontario's Action Plan for Health Care is to keep Ontario healthy. As such, the Government of Ontario formed the Healthy Kids Panel which consists of experts from a variety of sectors, including healthcare, academia, industry and Aboriginal communities. The scope of the Panel's work includes:

- The identification of the specific factors that impact childhood obesity rates in Ontario
- Identification and prioritization of the multi-sectoral strategies that have the potential to address childhood obesity in Ontario.

The Healthy Kids Panel recently released a report entitled No Time to Wait: The Healthy Kids Strategy. The Executive Summary is attached as Appendix A. It identifies that the strategy sets a goal to reduce childhood obesity by 20 % in five years. The startling statistics speak to the urgency of this matter. Although the *Healthy Kid's Panel* refers to their target as 'bold', they expect it is 'feasible and achievable'.

The over-arching goals of the strategy is to make children's health everyone's priority. This entails investing in child health through a variety of activities, including:

- Maintaining current funding levels
- Leveraging and repurposing government funding
- Establishing a public-private philanthropic trust fund that relates to innovation

The use of evidence, monitoring progress, and ensuring accountability are also identified as components of this strategy.

Recommendations from the Report

Report recommendations are meant to lay a foundation which will benefit the health of children and reduce future health care related spending.

The three strategic recommendations from the report include:

- Starting all kids on the path to health by enhancing prenatal care for families and promoting breastfeeding
- Changing the food environment to increase the availability of healthy choices and expand nutrition programs in schools
- Building healthy communities that encourage healthy eating and active living. This will consist of:
  - Developing a comprehensive social marketing program whereby the program not only targets children and youth, but also parents.
  - Making schools hubs for child health and community engagement
  - Creating healthy environments for preschool children
  - Developing the knowledge and skills of key professionals to support parents
  - Ensuring families have timely access to specialized obesity programs

As well the report identifies provincial strategies that are working upstream to address the underlying causes of unhealthy weights. These approaches, along with support for health inequities reductions programming, will be crucial for addressing childhood obesity and its health impacts.

Conclusion/Next Steps

This report aligns with much existing Health Unit programming. Health Unit staff members remain committed to implementing obesity reduction strategies in partnership with the County of Middlesex and the City of London, the Child & Youth Network and other community stakeholders. In addition, the recommendations of this report support the Health Unit's strategic direction in the area of healthy eating and physical activity.

Additional considerations for the Health Unit as it moves forward may include working with community partners to:

- Make schools hubs for child health and community engagement.
- Ensure families have timely access to focused obesity programs.
- Enhance the involvement of parents.
- Continue to build upon current upstream approaches, including programming that relate to the Poverty Reduction Strategy, Mental Health and Addictions Strategy, and health inequities reductions initiatives within the community.

This report was prepared by Ms. Deb Fenlon, Public Health Nurse and Ms. Diane Bewick, Director & Chief Nursing Officer, Family Health Services.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Reproductive Health Standard, Child Health Standard and Chronic Disease & Injury Prevention Standard.

Executive Summary

Parents in Ontario want their children to grow up healthy, happy and ready to succeed in life. But, childhood overweight and obesity are undermining children's health. Almost one in every three children in Ontario is now an unhealthy weight. The problem is more severe in boys than girls, and in Aboriginal children.

Overweight and obesity are threatening our children's future and the future of our province, which looks to its children for the next generation of citizens and leaders. If our children are not healthy, then our society will not flourish. Overweight and obesity also threaten the sustainability of our health care system. In 2009, obesity cost Ontario $4.5 billion.[1] To create a different future, we must act now!

In January 2012, the Ontario Government set a bold, aspirational target: reduce childhood obesity by 20 per cent in five years.

The multisectoral Healthy Kids Panel was asked for advice on the best way to meet that target. The panel listened to parents and other caregivers, youth and experts in the field and reviewed the literature and strategies in Ontario and other jurisdictions.

The panel strongly recommends a bold, yet feasible and achievable, three-part strategy – one that will have the greatest positive impact on child health as well as a substantial return on investment for Ontario:

1. **Start all kids on the path to health.**
   Laying the foundation for a lifetime of good health begins even before babies are conceived, and continues through the first months of life. We must provide the support young women need to maintain their own health and start their babies on the path to health.
2. **Change the food environment.**
   Parents know about the importance of good nutrition. They told us they try to provide healthy food at home, but often feel undermined by the food environment around them. They want changes that will make healthy choices easier.
3. **Create healthy communities.**
   Kids live, play and learn in their communities. Ontario needs a co-ordinated all-of-society approach to create healthy communities and reduce or eliminate the broader social and health disparities that affect children's health and weight.

If nothing is done:

- the current generation of children will develop chronic illnesses much younger and be more affected as they age
- the cost of obesity will grow, impacting our ability to fund other programs and services.

No one policy, program or strategy will solve the problem of childhood overweight and obesity.

We heard loud and clear from parents that their children's health is their top priority, but they need some support to help their children become and stay at a healthy weight. Everyone has a role to play in supporting parents' efforts to ensure their children grow and thrive. We need action everywhere – from parents, caregivers and kids themselves, child care settings and schools, health care providers, non-governmental organizations, researchers, the food industry, the media, and municipal and provincial governments – and a willingness to take risks.

Ontario is at a tipping point. Parents, youth and everyone we spoke to are ready to be part of the solution. If Ontario acts quickly and implements all the recommendations in this report, it is possible to change the trajectory and bring kids' weight back into balance. But we must start now and sign on for the long term – at least 10 years. If we delay, we run the risk of more aggressive measures in the future.

[1] Katzmarzyk PT. (2011). The economic costs associated with physical inactivity and obesity in Ontario, *The Health and Fitness Journal of Canada*, Vol. 4, No. 4.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 115-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 October 17

HEALTH UNIT PARTICIPATES IN MUNICIPAL EMERGENCY EXERCISES

Recommendation

It is recommended that Report No. 115-13 re Health Unit Participates in Municipal Emergency Exercises be received for information.

Key Points

- The Emergency Management and Civil Protection Act (1990), requires all municipalities to test their emergency response plans by conducting an annual exercise
- On September 17th, 2013, Middlesex County conducted emergency exercises in Middlesex Centre and Southwest Middlesex
- The Emergency Preparedness Protocol in the Ontario Public Health Standards also requires Health Units to exercise at least once annually all or some components of their emergency response plans
- In June 2013, the Health Unit's emergency exercise tested the assigned staff in alternate positions on the Incident Management Team in a "Heat Alert" scenario

The Emergency Management and Civil Protection Act (1990), requires all municipalities to test their emergency response plans by conducting an annual exercise. The Emergency Preparedness Protocol in the Ontario Public Health Standards also requires Health Units to exercise at least once annually all or some components of their emergency response plans.

On September 17, 2013, Middlesex County conducted emergency exercises in Middlesex Centre and Southwest Middlesex. Other municipalities in Middlesex had been tested in rotation over the past few years. Observers and Evaluators came from neighbouring municipalities.

Mayor Al Edmonson (Middlesex Centre) and Mayor Doug Reycraft (Southwest Middlesex) led their municipalities through the "Host Haste" exercise which tested the set-up and decision-making of the Emergency Operations Centres (EOC) and Evacuation/Reception Centres in Ilderton/Komoka and in Glencoe.

The theme of this exercise centered on the possibility of a mass evacuation of First Nation citizens from various communities in the northern parts of Ontario due to raging forest fires. These families were theoretically to arrive within mere hours and thus would need to be sheltered locally for at least five days in this region.

The Medical Officer of Health attended the EOC in Middlesex Centre and the Manager of Emergency Preparedness represented the MOH in Southwest Middlesex. Public Health Nurses and Inspectors attended the Evacuation/Reception Centres to ensure that the health needs of the 'evacuees' were met. Approximately twenty members of the health unit's Community Emergency Response Volunteers (CERV) joined with the full County CERV team and role played as evacuees presenting with various

medical and health needs. Some of the CERV team members assisted with the Registration and Inquiry process as well. In all, the Health Unit was well represented, participated fully and learned some valuable lessons which will be incorporated into the next revision of the Health Unit's Emergency Response Plan.

In June 2013, the Health Unit's emergency exercise tested the assigned staff in alternate positions on the Incident Management Team in a "Heat Alert" scenario. This was also an opportunity for many of the staff to meet and work with the new Medical Officer of Health.

The Health Unit's Manager of Emergency Preparedness is a member of the emergency planning committees in all eight municipalities as well as for Middlesex County itself and a regular member of the County's exercise design team. She also serves the same functional roles on the City of London planning and exercise design committees.

The City of London has planned its annual Emergency Exercise for Thursday, November 14, 2013, and the Health Unit will be active participants in the planning, development and execution.

This report was prepared by Ms. Patricia Simone, Manager of Emergency Preparedness.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Mandatory Health Programs and Services Guidelines:

The Ontario Public Health Standards – Emergency Preparedness Protocol (requirement #7)

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 116-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 October 17

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT – OCTOBER

Recommendation

It is recommended that Report No. 116-13 re Medical Officer of Health Activity Report – October be received for information.

The following report highlights activities of the Medical Officer of Health (MOH) from the September Medical Officer of Health Activity Report to October 7, 2013.

The MOH continued to be involved in the hiring for the position of Director of Human Resources and Strategic Priorities. On Friday September 27th, staff was advised that Ms. Laura Di Cesare was the chosen candidate to fill the position that is currently held by Louise Tyler. Ms. Di Cesare brings with her several years of experience from numerous Senior HR Management roles. Louise will be retiring before the end of the year and will be providing training and orientation to Ms. Di Cesare on a part-time basis until she retires.

With flu season just around the corner, the MOH participated in filming a segment of the Staff Immunization Campaign Video. This video was the creation of Vanessa Bell, Manager Privacy and Occupational Health and Safety, Barb Sussex, Staff Immunization Nurse and Lilka Young, Program Assistant and filmed by Keyframe Inc. Several staff and some family members also took part in this project which has resulted in a great motivational video encouraging staff to get vaccinated against seasonal flu.

On September 18th the MOH attended and spoke at the "in motion" launch at the Covent Garden Market. This event kicked-off the 31 day challenge for all residents of London and area to get moving and make London, Canada's Healthiest City.

On September 9th, the MOH met with new staff to the Health Unit as part of the Agency Orientation and presented on the Office of the Medical Officer of Health.

The MOH attended the United Way Harvest Lunch on September 19th at the Budweiser Gardens. This year's fundraising goal of 8.9 million was announced at the event.

Later in the day, the MOH took part in a stakeholder consultation with the London Police Services Board at Police Headquarters.

The MOH hosted a meeting of the Southwest Medical Officers of Health and Associate Medical Officers of Health, including representatives from eight of the health units in Southwestern Ontario. The agenda included several items of interest to the MOH such as: Low Risk Alcohol Drinking Guidelines (LRADG); Strategic Planning; and low immunization levels among some groups for pertussis and other vaccine preventable diseases. This meeting was valued by all participants, and the group agreed to hold meetings twice a year going forward.

The MOH was invited to provide opening remarks for a workshop for Health Care Providers – "Identifying Complexities and Solutions to Nurture Infant Mental Health". This workshop was organized by the Early Years Physician Champion Committee in conjunction with the Community Early Years Partnership under the leadership of Health Unit Public Health Nurses.

The MOH also spoke at the MLHU Infectious Disease Prevention and Control 2013 Workshop and Education event on October 3rd at the Hellenic Centre.

The Medical Officer of Health and CEO also attended the following teleconferences and events:

September 11 – Attended lunch meeting with City of London Councillor Paul Hubert
September 13 – Launched the new budget process with the Health Unit's extended management group
September 13 – Attended teleconference – Forum for Public Health and Mental Health Leaders: Planning Committee
September 16 – Attended meeting at Western University with Dr. Bertha M. Garcia
September 17 – Attended and participated in Middlesex County Emergency Exercise
September 18 – Attended meeting with Thames Valley District School Board and Health Unit staff to discuss strengthening partnerships
September 19 – Attended meeting of London's Homeless Prevention System – Implementation Team
September 23 – Attended meeting with Cynthia St. John from the Elgin St. Thomas Public Health
September 24 – Attended teleconference – Public Health Early Years Group
September 26 – Toured the Health Unit Strathroy Office with Dave Bolton, Marcel Meyer, Al Edmondson and John Millson
September 30 – met with Mayor Joe Fontana, Denise Brown, Marcel Meyer, City of London City Manager Art Zuidema and several City finance staff to discuss the new Health Unit budget process
October 2 - Met with CUPE and ONA reps about the new budget process
October 3 – Attended meeting of the Board of Health Finance and Facilities Committee
October 7 - Met with members of the London & Middlesex Local Immigration Partnership

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses Ontario Public Health Organizational Standard 2.9 Reporting relationship of the medical officer of health to the board of health

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 117-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 October 17

PROPOSED CRITERIA FOR 2014 BUDGET PROCESS

Recommendation

It is recommended that the Board of Health endorse the refined criteria presented in Report No. 117-13 re "Proposed Criteria for 2014 Budget Process."

Key Points

- Following approval of the Finance and Facilities Committee's recommended 2014 budget/planning timeline and process, staff have proposed refined the criteria for investments and dis-investments.
- The major refinements are (1) the addition of "ability to meet legislative requirements" and "organizational risks / benefits" as criteria, and (2) subdivision of the Ontario Public Health Standards principles into sub-components to be individually rated.

Background

At the September 2013 meeting, Board of Health members will recall approving the 2014 budget/planning timeline and process recommended by the Finance and Facilities Committee (FFC) (see Report No. 094-13). This process includes the use of "Program Budgeting and Marginal Analysis [PBMA], which transparently applies pre-defined criteria to prioritize where proposed decreases or increases could be made," to facilitate "reallocation of resources based on maximizing the value of services across the four principles of the Ontario Public Health Standards [OPHS] (Need, Impact, Capacity, and Partnerships/Collaboration)."

Since that meeting, staff have worked to operationalize these principles as criteria for decision-making. This work was done with the assistance of Prof. Craig Mitton and Dr. Francois Dionne, experts in the PBMA process.

Refinement of the Criteria

As reported at the Board of Health meeting in September, transforming the OPHS principles into PBMA criteria led to the addition of "ability to meet legislative requirements" and "organizational risks / benefits" as criteria. In the current proposed criteria, the OPHS principles are also divided into sub-components to be individually rated. The proposed criteria are described in Appendix A.

The two additional criteria were added because they provide valuable information regarding the risks associated with each proposal. During proposal evaluation, it will be important to know whether each proposal puts the Board at risk of not meeting a legislated requirement, as well as risk of litigation, diminished public reputation, or poor staff morale.

Sub-components were added to the OPHS principles on the guidance of Dr. Dionne. Based on his extensive experience with PMBA, Dr. Dionne reported that the use of specific criteria related to such issues as implementation challenges, client experience and equity will provide valuable information for informing the proposal evaluation process.

Next Steps

After finalization of the criteria, staff can begin developing proposals. However, before proposals can be submitted or evaluated, each criterion must be assigned a weight to reflect its relative importance. Board of Health members will be given the opportunity to discuss and decide criteria weights at the Board retreat on November 1.

This report was prepared by Mr. Ross Graham, Manager of Strategic Projects.

Christopher Mackie, MD, MHSc
Medical Officer of Health

Appendix A – Proposed Criteria for 2014 Budget Process

Criteria	Intent of the criteria	Information to be provided
1) Legislative requirement	To assess the impact of the proposed change on: 1. the ability of the program to meet the legislative requirements for this program / activity, if any; 2. the alignment of the proposed change with public policies at all levels.	Indicate if this program / activity is mandated under: • The Health Protection and Promotion Act via the Ontario Public Health Standards (OPHS) • Other legislation • Not mandated under legislation If mandated under the OPHS, indicate which standard / protocol mandates the requirement / activity and quote the specific requirement for this program / activity. Indicate if there is an accountability agreement indicator associated with this program and if so, what the indicator is. If mandated by other legislation, list the name of the legislation and the requirements under the legislation.
2) Health need	To describe the need for this program / activity change either in terms of: 1. the burden of illness it is intended to prevent and/or the risk factor it is intended to reduce; 2. the social determinant of health it is intended to address and/or health inequities	Describe the target group for the program (e.g., population as a whole, school children, people who use injection drugs, premise operators etc.) Using local statistics if possible, provide one or more of the following related to the issue being addressed by the program / activity: • Potential years of life lost • Mortality rate • Hospitalization rate • Rate of illness, rate of risk factor or rate of social determinant in our community compared to other communities or the province as a whole

3) Impact	To assess the expected impact of the proposed change to the program / activity on: 1. the burden of illness it is intended to prevent and/or the risk factor it is intended to reduce 2. the social determinants of health and/or health inequities 3. client experience	Evidence of expected impact of the proposed change can reflect on how the health needs parameters (outlined above) or other indicators, such as quality adjusted life years, are expected to change versus current care. If these are unavailable, impact on shorter term outcomes of the program / activity can be presented (e.g., impact on knowledge, skills, attitudes etc.) Sources of the information above can be published literature, evaluation reports, health status reports, surveillance data etc. Briefly describe what is found in those sources including key references with hyperlinks, if possible. If applicable, indicate how the proposed change will impact the social determinants of health (even if the program is not directly geared to addressing a social determinant of health). Impact on client experience includes: 1) the extent to which the care/service respects client and family needs and values, 2) client safety, 3) cultural appropriateness, and 4) the personal experience of communication, professionalism, and client focus. Indicate how nay negative impact could be mitigated.
4) Capacity	To describe if others in the community are doing some or all of this program / activity change or if it is unique to the Health Unit. Specifically, are others likely to fill in the gap in cases of disinvestments or retrench their services in cases of investments.	Indicate if there are others in the community who are doing all or part of this program / activity. Describe who else is doing some or all of the activity and what component they are doing. If proposing possible discontinuation of the program / activity, if appropriate, indicate if there are others who could take on this role.
5) Collaboration / Partnership	How does the proposed change affect the collaboration / partnership with respect to this program / activity in terms of how the collaboration / partnership contributes to meeting the Health Unit's goals?	Describe the partners involved in this program / activity. This can involve naming the partner organizations. Briefly describe what each partner contributes, as appropriate. Describe how being involved in this collaboration / partnership with regard to this program / activity supports the Health Unit in achieving its goal and how the proposed change will affect this collaboration/partnership.

6) Organizational risks / benefits	To assess the risks and / or benefits to the Health Unit of implementing the proposed change to this program / activity. In describing risks and benefits, specifically consider: 1. Organizational reputation and risk of litigation 2. implementation challenges (challenges to the implementation of the proposed initiative, including ease of sustainment, and impact on other MLHU front line or support services) 3. the impact on the culture of innovation and knowledge transfer of the organization and/or the workplace environment (including morale, personal and professional growth and teamwork)	If there are potential risks, describe strategies that could be used to mitigate the potential risks. Note the impact on partnerships is assessed separately above.